Interval Health History for Athletics
(filled out by parent/guardian, not physician)

Student Name:_____ DOB:_____

School Name: **Upton Lake Christian School** Age:_____

Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 Limitations: ☐ NO ☐ YES

Sport:_____ Date of last Health Exam:_____

Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity Date form completed:_____

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

Does or has your child…

Check yes or no

General Health

Yes ☐ No ☐ Ever been restricted by a health care provider from sports participation for any reason?
Yes ☐ No ☐ Ever had surgery?
Yes ☐ No ☐ Ever spent the night in a hospital?
Yes ☐ No ☐ Been diagnosed with mononucleosis within the last month?
Yes ☐ No ☐ Have only one functioning kidney?
Yes ☐ No ☐ Have a bleeding disorder?
Yes ☐ No ☐ Have any problems with hearing or have congenital deafness?
Yes ☐ No ☐ Have any problems with vision or only have vision in one eye?
Yes ☐ No ☐ Have an ongoing medical condition?

If yes, check all that apply:

- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Sickle cell trait or disease
- ☐ Other:_____

Breathing

Yes ☐ No ☐ Ever complained of getting extremely tired or short of breath during exercise?
Yes ☐ No ☐ Use or carry an inhaler or nebulizer?
Yes ☐ No ☐ Wheeze or cough frequently during or after exercise?
Yes ☐ No ☐ Ever been told by a health care provider they have asthma or exercise-induced asthma?

Devices / Accommodations

Yes ☐ No ☐ Use a brace, orthotic, or another device?
Yes ☐ No ☐ Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?
Yes ☐ No ☐ Wear protective eyewear, such as goggles or a face shield?
Yes ☐ No ☐ Wear a hearing aid or cochlear implant?

Let the coach/school nurse know of any device used.
Not required for contact lenses or eyeglasses.

Digestive (GI) Health

Yes ☐ No ☐ Have stomach or other GI problems?
Yes ☐ No ☐ Ever had an eating disorder?

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Yes ☐ No ☐ Have a special diet or need to avoid certain foods?
Yes ☐ No ☐ Are there any concerns about your child's weight?

Injury History

Yes ☐ No ☐ Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?
Yes ☐ No ☐ Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?
Yes ☐ No ☐ Have a bone, muscle, or joint that bothers them?
Yes ☐ No ☐ Have joints that become painful, swollen, warm, or red with use?
Yes ☐ No ☐ Ever been diagnosed with a stress fracture?

Allergies

Yes ☐ No ☐ Have any known allergies?

If yes, check all that apply:

- ☐ Food
- ☐ Insect Bite
- ☐ Latex
- ☐ Medicine
- ☐ Pollen
- ☐ Other:_____

___

Yes ☐ No ☐ Ever had anaphylaxis?
Yes ☐ No ☐ Carry an epinephrine auto-injector?

Brain/Head Injury History

Yes ☐ No ☐ Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?
Yes ☐ No ☐ Receive treatment for a seizure disorder or epilepsy?
Yes ☐ No ☐ Ever had headaches with exercise?
Yes ☐ No ☐ Ever had migraines?

Heart Health

Has your child ever experienced:

Yes ☐ No ☐ Lightheadedness, dizziness, during or after exercise?
Yes ☐ No ☐ Chest pain, tightness, or pressure during or after exercise?
Yes ☐ No ☐ Fluttering in the chest, skipped heartbeats, heart racing?
Yes ☐ No ☐ Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?
Yes ☐ No ☐ Have a heart or blood vessel problem?
Yes ☐ No ☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ Heart infection
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ New fast or slow heart rate
- ☐ Kawasaki Disease
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Has a pacemaker
- ☐ Other:_____

Females Only

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Yes ☐ No ☐ Have regular periods?

Males Only

Yes ☐ No ☐ Have only one testicle?
Yes ☐ No ☐ Have groin pain or a bulge, or a hernia?

Skin Health

Yes ☐ No ☐ Currently have any rashes, pressure sores, or other skin problems?
Yes ☐ No ☐ Ever had a herpes or MRSA skin infection?

COVID-19 Information

Yes ☐ No ☐ Has your child ever tested positive for COVID-19?
If NO, STOP. Go to Family Heart Health History. If YES, answer questions below:
Yes ☐ No ☐ Date of positive COVID test:_____
Yes ☐ No ☐ Was your child symptomatic?
Yes ☐ No ☐ Did your child see a health care provider for their COVID-19 symptoms?
Yes ☐ No ☐ Was your child hospitalized for COVID?
Yes ☐ No ☐ Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?

Family Heart Health History

Yes ☐ No ☐ Has a relative had any of the following?
If yes, check all that apply:
- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems: long or short QT interval?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart attack at age 50 or younger?

Yes ☐ No ☐ A family history of any of the following?
If yes, check all that apply:
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered NO to ***all*** questions, STOP. Sign and date below.
GO to page 4 if you answered YES to a question.

Parent / Guardian Signature:_____ Date:_____

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If you answered YES to any questions give details. Sign and date below.

Parent / Guardian Signature:_____ Date:_____