Niagara Falls City School District
NYSED Interval Health History for Athletics

Student Name:	DOB:
School Name:	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 in Pen and signed by Parent/Guardian - Give details to any YES answers on page 3.

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Brain/Head Injury History	**No**	**Yes**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

Does or Has Your Child

Breathing	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
Devices / Accommodations	**No**	**Yes**
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
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	**No**	**Yes**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
Injury History	**No**	**Yes**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:		DOB:	

Does or Has Your Child

Heart Health

Ever complained of:

Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

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

Does or Has Your Child

Females Only	No	Yes
Have regular periods?	☐	☐
Males Only	**No**	**Yes**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
Skin Health	**No**	**Yes**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 Information		
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

Family Heart Health History

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems, long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ 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 3 to explain any **YES** question.

PARENT PERMISSION Your signature below is required for sports participation and indicates that you give permission:

1. The district Medical Staff to obtain medical information from your child's health care provider **if necessary**.
2. For the school Health office to disclose pertinent health information to the coaches.
3. To the Nurse Practitioner/Medical Director to provide a pre-athletic sports evaluation on your child
4. That all the above answers are correct to the best of your knowledge.

Signature of Parent/Guardian _____ Current Phone # _____ Date _____

Student to fill out health questionnaire and sign on page 3

D14a/b 6/22

FOR SCHOOL NURSES ONLY:

Matches CHR ☐ Yes ☐ No List Discrepancies in progress note and attach School Nurse Initials _____ Date _____

Student Name:		DOB:	

Student to fill out Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days Over	Over half the days	Nearly every day
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

Signature of Athlete _____ Date _____

If you answered **YES** to any questions give details. Sign and date below.	
Parent/Guardian Signature:	Date:

FOR SCHOOL NURSES TO COMPLETE IF USED AS AN INTERVAL HEALTH HISTORY.

Date of last sports physical: ____/____/____ Limitations: ☐ Yes ☐ No

STUDENT IS CURRENTLY DISQUALIFIED FOR MEDICAL REASONS: _____ YES _____ NO

Sports Participation: _____ Restrictions: _____

____Approved ___Referred to Nurse Practitioner or School Physician

School Nurse Signature _____ Date___/___/___

If referred to the Nurse Practitioner or School Medical Director:

Student Name:		DOB:	

____Re-qualified ___Disqualified

Nurse Practitioner Signature _____ Date___/___/___

School Medical Director Signature _____ Date___/___/___