

Niagara Falls City School District
PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY

PART A: To be completed by student

School Name: _____

Student Name: _____ DOB: ____/____/____

Grade (check): 7 8 9 10 11 12

Sport: _____ Level (check): Varsity JV Modified

Date of last health exam: ____/____/____ Limitations: Yes No Date IHHX form completed ____/____/____

PART B: To Be Completed by Parent/Guardian in Pen, signed and dated. Provide details to any yes answers or other pertinent information on back of this form.

	YES	NO	DATE
Ever been restricted by a doctor or Nurse practitioner from sports participation for any reason?			
Have an ongoing medical condition? Please check below: <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Seizures <input type="radio"/> Other <input type="radio"/> Sickle Cell (SC) <input type="radio"/> SC Trait			
Ever had surgery?			
Ever spent the night in a hospital other than the ER?			
Have a life threatening allergy? <input type="radio"/> Medication <input type="radio"/> Food <input type="radio"/> Insect Bites <input type="radio"/> Pollen/Seasonal <input type="radio"/> Latex <input type="radio"/> Other			
Carry an Epinephrine auto-injector(Epi-Pen)?			
Ever complained of light headedness or dizziness during or after exercise?			
Ever complained of chest pain, tightness or pressure during or after exercise?			
Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does she/he have a pacemaker?			
Has a health care provider ever ordered a test for his/her heart? (such as an EKG, echocardiogram, stress test)			
Ever been told they have a heart condition or problem? <input type="radio"/> heart murmur <input type="radio"/> heart infection <input type="radio"/> high cholesterol <input type="radio"/> high or low blood pressure			
Ever become ill while exercising in hot weather?			
Ever complained of getting more tired or short of breath than his/her friends during exercise?			
Wheeze or cough frequently during or after exercise?			
Ever been told by their health care provider they have asthma?			
Use or carry an inhaler or nebulizer?			
On a special diet or have to avoid certain foods?			

	YES	NO	DATE
Have they ever taken vitamins or supplements or worry about their weight?			
Have stomach problems?			
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told she/he had a concussion?			
Ever have headaches with exercise?			
Ever had a seizure?			
Currently being treated for a seizure disorder or epilepsy?			
Ever been unable to move his/her arms and legs or had tingling, numbness, or weakness after being hit or falling?			
Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?			
Has She/he ever broken or fractured any bones or dislocated any joints?			
Use a brace, crutches, cast, orthotic or other device?			
Have any problems with his/her hearing or wear hearing aids?			
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, kidney shield, protective lenses etc.)			
Have any problems with his/her vision or have vision in only one eye?			
Wears glasses or contacts?			
Ever had a hernia?			
Does she/he have only 1 functioning kidney?			
Does she/he have a bleeding disorder?			
Males only: Hernia check is part of the physical exam			
Does he only have one testicle?			
Females only: Please wear tank top under clothing day of physical.	AGE	# of times	DATE
What age did she have her first menstrual period?			
Date of last menstrual period?			
How many times did she get her period in past year?			

Please continue on back

