Plattsburgh High School

PREPARTICIPATION/INTERVAL ATHLETIC/New Student/10th grade/Annual HEALTH HISTORY
Two Page Form

Student Name: _____DOB: ____/____/_____ Sport_____

Grade (check): ❑ 9 ❑ 10 ❑ 11 ❑ 12 Today's Date ____/____/_____ ❑ Varsity ❑ JV

Date of last Physical Exam: _____/_____/_____ Limitations: ❑ Yes ❑ No_____

Health History To Be Completed By Parent/Guardian – Required for *each* Sports Clearance

Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back page:

Question	YES	NO
Has a MD. PA or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: □ Asthma □ Diabetes □Seizures □ Other □ Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have any allergies/ life threatening allergy? Please check below: □ Medication □ Food □ Insect bites □ Seasonal □Latex □ Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition, murmur or problem?		
Has s/he ever had high or low blood pressure? High Cholesterol?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Any weight loss/gain in the last year?		

Question	YES	NO
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, loss of consciousness or been told s/he had a concussion?		
Does s/he ever have headaches with exercise? Or history of migraine?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever had an injury, pain, or swelling, fracture or dislocation of a joint that caused him/her to miss practice or a game? Please indicate details on pg. 2		
Does s/he use a brace, orthotic or other device? Does s/he have oral braces/retainer?		
Does s/he have any problems with his/her hearing or wear hearing aids?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin? _____		
How often does she get her period?		
Date of last menstrual period_____		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

Has your child experienced any emotional problems?
Stress, _____ Anxiety _____ Depression_____

Turn to Page 2

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Page 2

Please List Current Medications: _____

_____

_____

_____

Please explain fully any question you answered yes to in the space below
(Please print clearly, and provide dates if known):

_____

_____

_____

_____

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_____

I certify that to the best of my knowledge my answers are complete and true.

Parent/Guardian signature **Date**

Please indicate (√) below if you prefer your child to have a school physical or private physical exam

_____**School Physical** _____**Private Physical**

The Plattsburgh City School District has implemented a Concussion Management Plan in accordance with the Concussion Management and Awareness Act. Any student who has sustained, or believed to have sustained a head injury in or out of school will be removed from play. Students will need to **complete a return to play process with clearance from the School Physician** in order to return to full physical participation in school athletic activities. Computerized neurocognitive baseline testing will be used as an assessment tool in concussion management. Further information is available through the PCSD website and by contacting your student's school nurse. Parent permission for student participation in the PCSD Concussion Management Plan:

Parent/Guardian Signature: _____ Date: _____

I authorize the school nurse to share pertinent information regarding my child's health with only the involved staff of Plattsburgh High School and the student's primary care physician. This authorization shall remain in effect for this school year.

Parent/Guardian Signature_____ Date:_____