# ALEXANDER HAMILTON HIGH SCHOOL
# INTERVAL HEALTH HISTORY FORM

Prior to the start of tryout sessions or practices at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

**PART A – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

Student: ______________________ Age _____

Grade: ____________ DOB _____/_____/_____

Sport & Level _________________

Date of last health appraisal ______/______

**Part B – <u>TO BE COMPLETED BY THE PARENT OF GUARDIAN</u>**

Note: Yes to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school physician before the students can report to practice or tryouts.

The answers to the questions of this form will be held in the school health office and will be kept confidential.

**HISTORY SINCE LAST HEALTH APPRAISAL:**

<u>If the answer to any of the following questions is "YES", then in PART C, on the reverse side of this Form please describe the condition or situation that prompted your answer</u>.

(please check)

| | | Yes | No |
|---|---|---|---|
| 1. | Any injuries requiring medical attention? | ☐ | ☐ |
| 2. | Any illness lasting more than 5 days? | ☐ | ☐ |
| 3. | Taking medicine or under physicians care at this time? | ☐ | ☐ |
| 4. | Any feeling of faintness, dizziness or fatigue after exercise? | ☐ | ☐ |
| 5. | Change in wearing glasses or contact lens? | ☐ | ☐ |
| 6. | Any surgical operations of fractures? | ☐ | ☐ |
| 7. | Any treatment in a hospital or emergency room? | ☐ | ☐ |
| 8. | Developed any allergies? | ☐ | ☐ |
| 9. | Any chronic disease? | ☐ | ☐ |

**PART C – TO BE COMPLETED BY PARENT OR GUARDIAN**

Describe the condition or the situation that caused any questions in PART B to be answered "YES"

______________________________________________________________________________

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**PART D – PARENTAL PERMISSION**

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date, and he/she has my permission to participate.

**Signature of Parent of Guardian: ______________________________ Date: _____/_____/_____**

**PLEASE RETURN THIS COMPLETED FORM TO THE NURSE'S OFFICE .**

**PART E – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

Sports Participation (check one)

- ☐ Approved
- ☐ Referred to School Physician

**Signed:** _________________________________ Date: _____/_____/_____

School Health Office

If referred to the School Physician check results:

- ☐ Re-qualified.
- ☐ Disqualified

**Signed:** _______________________________ Date: _____/_____/_____

School Physician