Port Jervis School District Interval Health History Form For Sports Participants

TO BE COMPLETED BY A PARENT OR GUARDIAN

Student: _____ Age: _____ Date of Birth: _____
Grade: _____ Date of Last Health Appraisal: _____
Sport: _____ Level: (check): ___Varsity ___JV ___ Modified

HEALTH HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is "YES", please explain below:

1.	Any injuries requiring medical attention?	yes	no
2.	Any illness lasting more than 5 days?	yes	no
3.	Taking any medication or currently under a Dr.'s care?	yes	no
4.	Fainting, dizziness or fatigue after exercise or exertion?	yes	no
5.	Change in wearing glasses or contact lenses?	yes	no
6.	Any operations or broken bones?	yes	no
7.	Any treatment in the hospital or Emergency Department?	yes	no
8.	Developed any new allergies?	yes	no
9.	Any chronic illness (i.e. asthma, diabetes, seizures)	yes	no
10.	Need to wear any protective equipment?	yes	no
	If yes, please circle: knee-brace, hearing aid, mouth guard, sports goggles		

Please describe & give dates for any of the above answered "YES":

_____
_____

PARENTAL PERMISSION:

I, the undersigned, clearly understand these questions are asked in order to determine if my child can safely participate in the Port Jervis School District Athletic Program. The answers are correct and accurate to date. My child has my permission to participate.

Parent/Guardian Signature: _____Date: _____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: _____ Approved _____ Referred to School Physician

Signed: _____ Date: _____
School Health Office

If referred to the School Physician:
_____ Requalified _____ Disqualified

Signed: _____ Date: _____
School Physician

This form must be completed no earlier than 30 days before the sport begins unless a full medical exam has been done within 30 days of the start of the sports season.

Note: "YES" to any of the questions does not mean automatic disqualification from the athletic activity. However, it will require a review & approval by the school physician before the student can report to practice or try outs.

PARENT SIGNATURE REQUIRED ABOVE & ON THE OPPOSITE SIDE OF THIS FORM