St. Joseph by-the-Sea Athletic Department Health & Medical / Dominic Murray NYSED Interval Health History

Student Name:		
DOB:	Grade:	
Address:		
Sport:		SportLevel: ☐Modified ☐Fresh ☐JV ☐Varsity
Emergency Contact:		
Parent/Guardian Name:		Relationship:
Address:		
Cell Phone:	**Home Phone:**	**Work Phone:**
Other Person to Contact:		

Ongoing medical conditions. Check all that apply:	**GENERAL HEALTH - Has/Does your child:**	Allergies
☐ Asthma ☐ Sinus Troubles ☐ Tuberculosis ☐ Diabetes ☐ Sickle cell trait or disease ☐ Fainting Spells ☐ Rheumatic Fever ☐ Epilepsy ☐ Kidney Disease ☐ Hay Fever ☐ Earache/Infection ☐ Severe stomach aches	☐ 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? ☐ For Girls: Menstrual Problems	If yes check all that apply ☐ Food ☐ Insect bite ☐ Pollen ☐ Latex ☐ Medicine ☐ Ever had anaphylaxis? ☐ Carry an epinephrine auto-injector? ☐ Other Allergies? List Below.

FAMILY HEART HEALTH HISTORY	
☐ Enlarged Heart	☐ Marfan Syndrome (aortic rupture)?
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?	☐ Heart attack at age 50 or younger?
☐ Heart rhythm problems: long or short QT interval?	☐ Pacemaker or implanted cardiac defibrillator (ICD)?
☐ Brugada Syndrome?	☐ Known heart abnormalities or sudden death before age 50?
☐ Catecholaminergic Ventricular Tachycardia?	☐ Structural heart abnormality, repaired or unrepaired?
☐ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	☐ Unexplained fainting, seizures, drowning, or car accident before age 50?

Parents Authorization: This health history is correct so far as I know. The person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician/medical facility selected by the school/coach in charge to hospitalize, secure proper anesthesia, or to order injection/surgery for my son/daughter.

Parent / Guardian Signature: _____ Date: _____

IF you answered **YES** to ***any*** questions on page 1, PLEASE CONTACT YOUR PHYSICIAN for **cardiac evaluation** and **clearance**. **Physicians MUST sign/date for clearance *AFTER* cardiac evaluation.**

MUST BE FILLED BY A PHYSICIAN

Physical Evaluation

Height: _____ Weight: _____ Blood Type: _____

Check Box if Normal	Check Box if Normal	
☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Teeth ☐ Dentures ☐ Braces	☐ Lungs ☐ Abdomen ☐ Genitalia ☐ Extreneites ☐ Posture (spine) ☐ Skin	Urinalysis: Sugar? _____ Albumin? _____ Blood Pressure _____ If indicated: Blood Count: _____ Chest Plate _____ Tuberculin Test _____

General Appraisal: _____

_____

I certify that I have today received the health history and examined this person and find him/her physically fit to participate in:

Baseball: _____	Basketball: _____	Bowling: _____
Cheerleading: _____	Fencing: _____	Football: _____
Archery: _____	Dance: _____	Lacrosse: _____
Ice Hockey: _____	Soccer: _____	Softball: _____
Swimming: _____	Sailing: _____	Tennis: _____
Track: _____	Volleyball: _____	Wrestling: _____

Recommended and/or restrictions (if none, so state):

_____

_____

Physician signature :	
Date signed :	
Physician Telephone	
Physician Address	