

**Wynantskill Union Free School District
25 East Avenue
Troy, NY 12180**

Athletic Health History/Sports Update Form

Name _____ Sport _____

Date of Birth _____ Grade _____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE HEALTH OFFICE BEFORE A STUDENT CAN RECEIVE CLEARANCE FOR SPORTS, AND BEFORE A PHYSICAL EXAM WILL BE PERFORMED BY THE SCHOOL HEALTH CARE PROVIDER.

Does your child have a history of any of the following?

	Yes	No		Yes	No
Asthma	___	___	Elevated Blood Pressure	___	___
Bee Sting Allergy	___	___	Headaches	___	___
Allergies	___	___	Head Injury/Concussion	___	___
Anemia	___	___	Heart Problem/Murmur/ Chest Pain	___	___
Arthritis	___	___			
Bladder/Kidney Problem or injury	___	___	Nosebleeds/frequent or severe	___	___
			Ankle Injury	___	___
Convulsions/Seizures	___	___	Back Pain/Injury	___	___
Fainting Spells	___	___	Fracture/Dislocation-Bones or joints	___	___
Diabetes	___	___			
Ear Problems/ Hearing Loss	___	___	Knee pain/Injury	___	___
Eye Problems/ Vision Loss	___	___	Neck Injury	___	___
Injury to the Spleen	___	___	Nose Fracture	___	___
Joint Sprain/ Ligament Tear/ Muscle Pull	___	___	Rheumatic Fever	___	___
Single Kidney	___	___	Stomach Ulcer	___	___
			Single Testicle	___	___
Severe allergy requiring the use of an Epipen?				___	___
History of heart murmur, irregular beat, or enlarged heart?				___	___
Prior occurrence of chest pain/ discomfort, or fainting with exercise?				___	___
Excessive and unexplained shortness of breath or fatigue with exercise?				___	___
Has your child ever been in Adaptive Physical Education, or limited from competitive sports?				___	___
Does your child wear glasses or contact lenses?				___	___
Does your child have an orthodontic appliance or capped teeth?				___	___

IN THE PAST 12 MONTHS HAS YOUR CHILD:	Yes	No
Had any injuries requiring medical attention?	___	___
Had any illness lasting more than 5 days?	___	___
Been unconscious or lost memory due to a blow on the head?	___	___
Been treated in a hospital or emergency room?	___	___
Had infectious mononucleosis?	___	___
Taken any medications (including inhalers) under a physician's care?	___	___
Is your child taking any my medication now?	___	___

**New York State requires pupils needing prescribed or over the counter medications during school or school related activities have parent's and physician's written consent on file with the School Nurse.

FAMILY HISTORY

Death from cardiac (heart) disease or sudden death before age 50?	___	___
Significant disability for cardiovascular disease before age 50?	___	___

**If you have answered YES to any of the above questions, please describe and give the date of illness/injury if applicable. Yes answers do not mean automatic disqualification, however, written clearance from your physician may be required to participate.

To my knowledge, there is no medical reason that my son/daughter cannot participate in Interscholastic Sports.

I also agree to emergency medical treatment as deemed necessary by the physician designated by school authorities.

PARENT SIGNATURE _____ DATE _____

 To Be Completed By School Health Office

Sports participation:

_____ Approved

_____ Refer to school physician

Signed _____
 (School Health Office)

Date _____

If referred to school physician:

_____ Qualified

_____ Disqualified

Signed _____
 (School physician)

Date _____