Wynantskill Union Free School District
Athletic Health History/Sports Update Form

* Valid 30 days from start date of each sport season*

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? If there are any "yes" answers, you will need to explain on the back.

	Yes	No		Yes	No
Asthma	___	___	Elevated Blood Pressure	___	___
Bee Sting Allergy	___	___	Headaches	___	___
Allergies	___	___	Head Injury/Concussion	___	___
Anemia	___	___	Heart Problem/Murmur/		
Arthritis	___	___	Chest Pain	___	___
Bladder/Kidney					
Problem or injury	___	___	Nosebleeds/frequent or severe	___	___
			Ankle Injury	___	___
Convulsions/Seizures	___	___	Back Pain/Injury	___	___
Fainting Spells	___	___	Fracture/Dislocation-Bones		
Diabetes	___	___	or joints	___	___
Ear Problems/					
Hearing Loss	___	___	Knee pain/Injury	___	___
Eye Problems/					
Vision Loss	___	___	Neck Injury	___	___
Injury to the Spleen	___	___	Nose Fracture	___	___
Joint Sprain/					
Ligament Tear/			Rheumatic Fever	___	___
Muscle Pull	___	___	Stomach Ulcer	___	___
Single Kidney	___	___	Single Testicle	___	___

	Yes	No
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
Been diagnosed with COVID-19? If so, medical clearance by your private physician is required.	___	___
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 _______________________________ Date ________________
(School Health Office)
If referred to school physician:
______ Qualified ______ Disqualified

Signed_____________________________ Date_______________
(School physician)