ALL 3 FORMS MUST BE TURNED IN TO YOUR COACH ON THE FIRST DAY OF PRACITCE TO BE ELIGIBLE TO PLAY*

*(Health history form, concussion form and emergency card)

Berlin Central School District - School Health Services

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to starting practice at the beginning of EACH Sports season, a Health History Form AND Concussion Form must be completed and signed by PARENT AND STUDENT and reviewed and approved by the Health Office.

Student Name:_____ Age:_____

Grade (check one): __7th __8th __9th __10th __11th __12th

Sport: Basketball Cheerleading Wrestling Swimming Boys Volleyball (circle one)
Date of last health appraisal: ___/___/___ Limitations: __Yes __No

TO BE COMPLETED BY PARENT OR GUARDIAN:

Note: "Yes" to any of these qualifications does not mean automatic disqualification from the athletic activity indicated above. However, it may require a review and approval by the school physician before student can report to practice or tryout.

HEALTH HISTORY:

Allergies (Bee sting/medications/food/latex, etc.)	___Yes ___No
Does the student carry an Epi-pen for a life-threatening allergy?	___Yes ___No
Concussion/Head Injury/Seizure	___Yes ___No
Asthma	___Yes ___No
Does the student carry an inhaler?	___Yes ___No
Recent injury that requires medical attention or protective equipment	___Yes ___No
Recent illness lasting more than one week (ie Mono)	___Yes ___No
Currently taking medications	___Yes ___No
Diabetes	___Yes ___No
Heart/blood pressure problems	___Yes ___No
Heat Exhaustion or Stroke	___Yes ___No

Bleeding Tendency/Anemia	___Yes ___No
Recent surgery or hospitalization	___Yes ___No
Kidney/liver disease	___Yes ___No
Contact lenses	___Yes ___No
Is there any medical condition aggravated by playing sports?	___Yes ___No

Describe the condition or situation that causes any of the above to be answered "Yes." Please indicate dates if applicable.

_____
_____
_____

PARENTAL PERMISSION

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

Signed:_____ 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

Revised 1/22/16