

**CITY SCHOOL DISTRICT OF NEW ROCHELLE  
INTERVAL ATHLETIC HEALTH HISTORY**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_ HR: \_\_\_\_\_

Sport: \_\_\_\_\_

Coach: \_\_\_\_\_

**Note to parents:** As required by the New York State Education Department, a physical exam is performed annually in order for a student to participate in intramural athletics. One of our School Physicians must clear each student athlete and specify in which categories of sports he or she may compete. For each new season, the parent and student are required to complete the Interval Athletic Health History. It will be reviewed by the School Nurse and referred to the School Physician if necessary. The School Physician will determine whether further evaluation is required.

**Note to School Nurses:**

- A. A student should not be cleared if there has been an absence of >5 days unless the illness was not sports related and will not compromise the student's participation. Notes from the family physician may be necessary.
- B. Sports related injuries require notes from the orthopedist, family physician or the School Physician.
- C. In unclear situations, schedule the students for reexamination.

**MEDICAL HISTORY**

**For any YES response, please explain.**

1. How many days have you been absent since participating in your last sport? \_\_\_\_\_ days  
Reason: \_\_\_\_\_
2. Have you had any illnesses since participating in your last sport? YES [ ] NO [ ]  
Describe: \_\_\_\_\_
3. Have you had any accident or injury during or since participating in your last sport? YES [ ] NO [ ]  
Describe: \_\_\_\_\_
4. Have you visited your doctor or an Emergency Room for any reason since participating in your last sport? YES [ ] NO [ ]  
Describe: \_\_\_\_\_
5. Are you taking any medication? YES [ ] NO [ ]  
List: \_\_\_\_\_
6. During participation in your last sport, have you gotten unusually out of breath, had chest pains headaches, palpitations, or dizziness? YES [ ] NO [ ]  
Describe: \_\_\_\_\_
7. Have you ever fainted during exercise? YES [ ] NO [ ]
8. Has any family member under age 40 died suddenly or due to heart disease? YES [ ] NO [ ]  
Please give the cause, if known: \_\_\_\_\_
9. Have you lost, due to trauma or disease, an eye, a kidney, or a testicle? YES [ ] NO [ ]

I have read the above information and, to the best of my knowledge, I have answered the questions truthfully.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**FOR HEALTH OFFICE USE ONLY:**

[ ] Approved for participation

[ ] Referred to School Physician

\_\_\_\_\_ School Nurse

\_\_\_\_\_ Date