



Sports Recertification Form

Interval Health History

Fall

Winter

Spring

Student _____ M _____ F _____ Age _____

Grade _____ Birthdate _____ Sport _____ School _____

Building _____

To Parent or Guardian: Please complete this form if the Physical and Health History were done more than 30 days before the sport begins.

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If your child was examined and approved for participation in interscholastic athletics this school year, please complete the following:

NOTE: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

History Since Last Physical		Yes	No
1.	Has your child experienced any type of head injury or concussion requiring medical attention? If so, when? How many total concussions?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has your child received any injury requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has your child had any surgical operations, joint injuries, or fractured bones?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has your child been treated in a hospital or emergency room?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has your child been diagnosed with any condition requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Has your child experienced swelling or pain requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has your child missed any practices under/or games due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Has your child been absent from school for five (5) or more consecutive days (or an equivalent period during the summer) due to an accident or illness requiring medical care?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has injury or illness prevented your child from exercise or other athletic activities?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Is your child currently taking any prescription or nonprescription (over the counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Will your child carry any medication or pills or inhaler in school or at sports activities?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has your child experienced any feelings of faintness, dizziness or fatigue after exercise or exertion?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has there been any change in vision, such as wearing glasses or contact lens?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Has our child developed any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Has your child developed asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Females Only: When was your last menstrual period? _____	<input type="checkbox"/>	<input type="checkbox"/>
Describe the condition or situation that caused any questions listed above to be answered "YES":			

PARENT PERMISSION

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

Parent Signature _____

Date _____

Student Signature _____

Date _____

Work Phone _____

Home Phone _____

Cell Phone _____

*Please complete this form if the Physical and Health History were done more than 30 days before the sport begins.

Part B - To be completed by the school nurse:

Date of Last Health Appraisal: _____ Absences: _____ PE Excuses _____