Shenendehowa Central Schools

Sports Candidate Health History*

Must be submitted with the physical

For Parent/Guardian Use

This form should be completed prior to the physical, signed by parent and student, and available at the time of the physical. If not completed and returned, the school physician may not give final approval to play.

Last Name _____ First _____ D.O.B. _____ Sport:_____

School Yr. _____ Grade ____ School Building _____ Age _____ Sex: M / F

	ALL "YES" ANSWERS MUST BE EXPLAINED (BOX AT BOTTOM)	**Yes**	**No**
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you ever been hospitalized overnight?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
5.	Will you be carrying any medication or pills or inhaler in school or sport activities?	☐	☐
6.	Have you ever taken any supplements or vitamins to help you improve your performance?	☐	☐
7.	Do you have any allergies (for example: to pollen, medicine, food, or stinging insects)?	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
9.	Have you ever been dizzy or passed out during or after exercise?	☐	☐
10.	Have you ever had chest pain during or after exercise?	☐	☐
11.	Have you ever had high blood sugar (diabetes)?	☐	☐
12.	Do you tire more easily than you feel you should?	☐	☐
13.	Have you ever been diagnosed with anemia?	☐	☐
14.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
15.	Have you had high blood pressure?	☐	☐
16.	Have you ever been told you have a heart murmur?	☐	☐
17.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
18.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?	☐	☐
19.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
20.	Have you ever been diagnosed with blood or bleeding disorders?	☐	☐
21.	Do you have absent one kidney, testicle, eye, or ear?	☐	☐
22.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
23.	Have you ever had a head injury or concussion?	☐	☐
24	If yes to answer 23, If so, when? How many?		
25.	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
26.	Have you ever had a seizure or convulsion?	☐	☐
27.	Do you have frequent or severe headaches?	☐	☐
28.	Have you ever had numbness or tingling in your arms, hands, legs, or feet from a stinger, burner, or pinched nerve, or other condition?	☐	☐
29.	Have you ever had heat cramps, heat exhaustion, or heat stroke?	☐	☐
30.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
31.	Do you have asthma or lung disease?	☐	☐
32.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, foot orthotics, retainer on your teeth, hearing aid?	☐	☐
33.	Have you ever had any problem with your ears or hearing?	☐	☐
34.	Do you wear glasses, contacts, or protective eyewear?	☐	☐
35.	Do you have any other problem with your eyes or vision?	☐	☐

		Yes	No
36.	Have you ever had dental health problems or loss of tooth enamel?	☐	☐
37.	Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture? When?	☐	☐
38.	Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? ***If yes, check appropriate box and explain below.***	☐	☐

☐ Head	☐ Back	☐ Shoulder	☐ Elbow	☐ Wrist	☐ Finger	☐ Thigh	☐ Shin/Calf	☐ Foot
☐ Neck	☐ Chest	☐ Upper Arm	☐ Forearm	☐ Hand	☐ Hip	☐ Knee	☐ Ankle	

39.	Have you experienced abdominal discomfort, constipation, diarrhea, and/or bloating?	☐	☐
40.	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
41.	Has there been any unexplained weight loss or weight gain during the past six months?	☐	☐
42.	Are you uncomfortable with your body weight?	☐	☐
43.	Are you currently following any particular diet or weight reducing plan?	☐	☐
44.	Do you diet frequently?	☐	☐
45.	Do you avoid eating certain food groups?	☐	☐
46.	Have you ever tried to control weight by vomiting, using laxatives, diuretics, or diet pills?	☐	☐
47.	Do you have a history of eating disorders?	☐	☐
		☐	☐
	FEMALES ONLY	☐	☐
48.	Has there been a recent change in menstrual patterns?	☐	☐
49.	At what age did you experience your first menstrual period?_____		
50.	When was your most recent menstrual period? ___/___/___		
51.	How much time do you usually have from the start of one period to the start of another?_____		
52.	How many periods have you had in the last year?_____		
53.	What was the longest time between one menstrual cycle and the next in the last year?_____		

Explain "Yes" Answers Here (Identify each answer with question number)

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 complete and correct as of this date and he/she has my permission to participate.

Parent/Guardian Signature	Student Signature	Date ***Must be completed & dated within 2 days of the physical**
Home Phone	Work Phone	Cell Phone

For School Nurse Use:					
AB		**PE**		**Nurse**	

(Revised October 2012)