Longwood Central School District
Health History Form (Grades 7-12) – Sports

This form must be completed and signed by parent.
This form must be completed within the 30 day period of the start of sport season.

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form

School Name: ____

Student Name: ____ DOB: ____/____/____

Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Sport: ____Level (check): ☐ Varsity ☐ JV ☐ Jr. High

Date form completed: ____/____/____

Health History To Be Completed by Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following.

Provide details to any yes answer on back:

	YES	NO
Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
Have an ongoing medical condition? Please check below: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Other ☐ Sickle Cell Trait or Disease		
Ever had surgery?		
Ever spend the night in a hospital?		
Have a life threatening allergy ☐ Medication ☐ Food ☐ Insect Bites ☐ Pollen ☐ Latex ☐ Other		
Carry an epinephrine auto-injector?		
Ever passed out during or after exercise?		
Every complained of light headedness or dizziness during or after exercise?		
Every complained of chest pain, tightness or pressure during or after exercise?		
Every complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever tested them for his/her heart? (e. EKG, echocardiogram, stress test)		
Ever been told they have a heart condition or problem?		
Ever had high or low blood pressure?		
Ever complained of getting more tired or short of breath than his/her friends during exercise?		
Wheeze or cough frequently during or after exercise?		
Ever been told by their health care provider they have asthma?		
Use or carry an inhaler or nebulizer?		
Ever become ill while exercising in hot weather?		
On a special diet or have to avoid certain foods?		
Have to worry about their weight		
Have stomach problems		
Ever have headaches with exercise?		

	YES	NO
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Ever had a seizure?		
Currently being treated for a seizure disorder or epilepsy?		
Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Use a brace, orthotic or other device?		
Have any problems with his/her hearing or wear hearing aids		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)		
Have any problems with his/her vision or have vision in one eye only		
Wear glasses or contacts?		
Ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia		
Has any relative died suddenly before the age of 50 from unknown or heart related cause		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin? _______		
How often does she get her period? ___________________		
Date of last period? __________________		
Males Only	**YES**	**NO**
Does he have only one testicle?		

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PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Page 2

School Name: ____

Student Name: ____ DOB: ____/____/____

Please explain fully any questions you answered yes to in the space below (Please print clearly, and provide dates if know):

____
____
____
____
____
____
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COVID-19 Screening Questions:

Has your student athlete or anyone in your home been exposed to COVID-19 in the last 30 days? __________

Is your student currently experiencing a fever or other symptoms of COVID-19? ___________

Have you traveled outside of NYS in the last 14 days? __________

If Yes, from where and to where? ____

Please email completed forms to: JHSsportsclearance@longwoodcsd.org or HSsportsclearance@longwoodcsd.org according to the school your student athlete attends.

I certify that to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature: ________________________________ Date:______________

Date of last health exam: _____/_____/_____ Limitations: ☐ Yes ☐ No

Review by (Name and Title): ________________________________ Date: ___________

Medical clearance is void if the pupil has significant injury or is absent from physical education for 5 or more days due to illness, Student must be recertified before he/she is allowed to participate. Please contact your building nurse for information.

____ ____________________________ ______________________
Parent/Guardian Signature Phone Number Date