

NEWBURGH ENLARGED CITY SCHOOL DISTRICT – HEALTH SERVICES

**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

SCHOOL NAME: \_\_\_\_\_

**All students participating in Sports must have a physical exam on file for the current school year. Prior to beginning each subsequent season, an Interval Health History must be completed.**

PART A:

Student Name: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

ID # \_\_\_\_\_ Sport: \_\_\_\_\_ Level:  Varsity  JV  Modified

Date of last health appraisal: \_\_\_/\_\_\_/\_\_\_ Limitations: \_\_\_\_\_yes \_\_\_\_\_no

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

**Note:** “Yes” to any of these questions below does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office and will be kept confidential.

**HISTORY SINCE LAST HEALTH APPRAISAL:**

If the answer to any of the following questions is “YES” - on the reverse side of this form in PART C, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention? \_\_\_\_\_ yes \_\_\_\_\_ no
2. Any illness lasting more than five (5) days? \_\_\_\_\_ yes \_\_\_\_\_ no
3. Taking medicine or under physician’s care at this time? \_\_\_\_\_ yes \_\_\_\_\_ no
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? \_\_\_\_\_ yes \_\_\_\_\_ no
5. Change in wearing glasses or contact lenses? \_\_\_\_\_ yes \_\_\_\_\_ no
6. Any surgical operations or fractures? \_\_\_\_\_ yes \_\_\_\_\_ no
7. Any treatment in a hospital or emergency room? \_\_\_\_\_ yes \_\_\_\_\_ no
8. Developed any allergies? \_\_\_\_\_ yes \_\_\_\_\_ no
9. Any chronic disease? \_\_\_\_\_ yes \_\_\_\_\_ no

**PART C: TO BE COMPLETED BY PARENT OR GUARDIAN**

Describe the condition or situation that caused any questions in PART B to be answered "YES".

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**PART D: PARENTAL PERMISSION**

To the best of my knowledge, this health interval is correct. I realize that there is a risk of being injured that is inherent in all sports. I realize the risk of injury may be severe, including the risk of fracture, brain injury, paralysis or even death.

Understanding the above, I give permission for my son/daughter \_\_\_\_\_,  
a student in the Newburgh Enlarged City School District to participate in: \_\_\_\_\_.

**SPORT NAME**

SIGNED: \_\_\_\_\_  
Parent/Guardian Signature

DATE: \_\_\_\_\_

Address: \_\_\_\_\_

Home/Cell phone number: \_\_\_\_\_

**PLEASE RETURN TO THE SCHOOL HEALTH OFFICE**

**PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

**Sports Participation:**

\_\_\_\_\_ Approved

\_\_\_\_\_ Referred to School Physician

Signed: \_\_\_\_\_  
School Health Office NP/SNT/RN Signature

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

**If referred to the School Physician:**

\_\_\_\_\_ Requalified

\_\_\_\_\_ Disqualified

Signed: \_\_\_\_\_  
School Physician Signature

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