Pulaski Academy and Central School

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION
(30-DAY FORM)

Prior to the start of each sports season, New York State Education Law requires a health history review for all students (grades 7 to 12) who plan to participate in interscholastic team sports. This form must be completed by a student's parent or guardian within 30 days of the start of the season unless a full medical examination has been completed during that 30 day time period. A current physical exam dated within the past 12 months must be on file in the school.

Student Name: ____________________________________ DOB: _______________

Sport: ____ Grade: ______________

Since the last physical:

Any injuries requiring medical attention?	YES	NO	Any surgeries or fractures?	YES	NO
Any illness lasting more than 5 days?	YES	NO	Any concussions?	YES	NO
Any dizziness or fatigue on exertion?	YES	NO	Currently on medication?	YES	NO
Any change in wearing glasses or contacts?	YES	NO	Currently under medical care?	YES	NO

Any chronic disease (e.g. diabetes, seizure disorder, bleeding disorder)? YES NO

Any asthma or life-threatening allergies requiring emergency medication (e.g. inhaler, epipen)? YES NO

*Note: Students requiring emergency medications must complete an Independent Carry and Use Form with Provider Attestation and Parent Permission each school year.

Has a medical provider ever recommended limits on participation in competitive sports? YES NO

Has any relative died suddenly before the age of 50 from unknown or heart related cause? YES NO

If you answered 'yes' to any of the above questions, please explain:

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Parent/Guardian Permission

I certify that, to the best of my knowledge, my answers are complete and true. I understand these questions are asked in order to determine if my child can safely participate in the sport named above.

Name (print): _________________ Signature:________________________ Date: __________

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

Sports Physical Date: ________________

Sports Participation: ___ Approved ___ Referred to School Physician

School Health Office Signature: __________________________ Date: ___________

If referred to School Physician: ___ Qualified ___ Not Qualified

School Physician Signature: ______________________________ Date: ____________