Our Lady Queen of Apostles Regional Catholic School
Interval Health History for Sports Participation

Please complete both sides of this form. **Parent/Guardian Signature required**.

PART A: This form must be completed by the athlete's parent or guardian. **Please explain all YES statements on back of this form.** A YES does not mean automatic disqualification from the athletic activity. However, it may require a review and approval by the school physician before the athlete can report to practice or tryouts.

Student's Name:	DOB:
Grade (check): ☐6 ☐7 ☐8	Level (check): Middle School Sports
Sport:	Date of last health exam:

PART B. HEALTH HSITORY SINCE LAST HEALTH APPRAISAL	NO	YES
Ever been restricted by a health care provider (HCP) from sports participation for any reason?		
Allergies (Insect /Medicine/Food/Latex/Pollen/Other)		
Does your child carry an epinephrine auto injector for a life-threatening allergy?		
Asthma		
Does your child use or carry an inhaler/nebulizer?		
Concussion/Head injury/Seizures		
Recent injury that requires medical attention or protective equipment?		
Diagnosed with mononucleosis within the last month		
Currently taking medications		
Diabetes/Hypoglycemia		
Heart Condition/Blood Pressure Problems/ Pacemaker implant		
Heat Exhaustion or Stroke		
Hearing Impairment		
Bleeding Tendency/Anemia		
Recent Surgery or Hospitalization		
Kidney/Liver Disease		
Contact Lenses/Vision impairment		
Is there any medical condition that might be aggravated by playing sports?		
Any ongoing medical conditions?		
Any complaints of chest discomfort, racing heart, light headiness, dizziness during or after exercise?		
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?		

PART B. HEALTH HSITORY SINCE LAST HEALTH APPRAISAL	NO	YES
Special Devices: insulin pump/continuous glucose monitoring system/prosthetic/ostomy bag/other		
Has your child ever tested positive for COVID-19? If yes, answer ** questions below		
**Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.		
**Was your child hospitalized? If yes, provide date(s)?		
**Was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		

Please explain fully any question you answered yes to in the space below, include dates if known. Use additional pages if necessary.

PART C: PARENT/GUARDIAN 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 in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: _____/_____/_____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART D: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: ❑ Approved ❑ Referred to School Physician

Signed: _____ Date:_____/_____/_____
School Health Office

If referred to the School Physician: ❑ Requalified ❑ Disqualified

Signed: _____ Date:_____/_____/_____