Homer Central School District  
P.O. Box 500  
Homer, NY 13077  

INTERVAL HEALTH HISTORY  

Prior to the start of tryout sessions or practice at the beginning of each season, an interval health history review for each athlete must be conducted unless the student received a full medical examination within thirty (30) days of the start of the season.

**Part A.**

<table>
<thead>
<tr>
<th>Date: _______________</th>
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<tbody>
<tr>
<td>Student: _________________________________</td>
</tr>
<tr>
<td>Age: ______________</td>
</tr>
<tr>
<td>Grade: ______________</td>
</tr>
<tr>
<td>D.O.B. ____________</td>
</tr>
<tr>
<td>Sport: ___________________________</td>
</tr>
<tr>
<td>Level: □ Var □ JV □ Frosh □ Jr. High</td>
</tr>
<tr>
<td>Date of Last Health Exam: ____________________  Last Tetanus: ____________________</td>
</tr>
<tr>
<td>Limitations: □ yes □ no</td>
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</tbody>
</table>

**Part B. To be completed by the parent or guardian**

Note: “Yes” to any of these questions 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 is “YES” to any of the following questions in Part C on the reverse side of this form, 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. Develop any allergies? YES ____ NO ____
9. Any chronic disease? (asthma, diabetes, heart murmur, etc.) 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”
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

### Part D. Parental 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: ____________________

### Part E. 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:**

- [ ] Qualified  - [ ] Disqualified

Signed: ________________________________  Date: ____________________

School Physician

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**PLEASE RETURN TO THE SCHOOL HEALTH OFFICE**