Homer Central Scool District
P.O. Box 500
Homer, N.Y.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. Date_____

Student: _____ Age_____

Grade_____ D.O.B._____

Sport:_____ Level:☐ Var ☐ JV ☐ Frosh ☐ Jr.High

Date of last Health Exam_____ Last Tetanus_____

Limitations: ☐ yes ☐ no

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 names 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 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