

**INTERVAL HEALTH HISTORY REVIEW FOR SPORTS PARTICIPATION AND PARENT CONSENT FORM  
(30 DAY FORM)**

Prior to the start of tryout sessions or practice at the beginning of each season, state regulations mandate that a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

If your child was examined and approved for participation in interscholastic athletics this school year, please complete the following:

**HISTORY SINCE LAST HEALTH APPRAISAL - TO BE COMPLETED BY THE PARENT OR GUARDIAN**

If the answer to any of the following questions is Yes, please describe the condition or situation that prompted your answer (please check either "yes" or "no").

- |   |     |    |
|---|-----|----|
| 1. Has your child experienced any type of head injury or concussion requiring medical attention?  | YES | NO |
| 2. Has your child received any injury requiring medical attention?  | YES | NO |
| 3. Has your child had any surgical operations, joint injuries, or fractured bones?  | YES | NO |
| 4. Has your child been treated in a hospital or emergency room?   | YES | NO |
| 5. Has your child been diagnosed with any condition requiring medical attention?  | YES | NO |
| 6. Has your child experienced swelling or pain requiring medical attention?   | YES | NO |
| 7. Has your child missed any practices and/or games due to illness or injury?   | YES | NO |
| 8. Has your child been absent from school for five (5) or more consecutive days (or an equivalent period during the summer) due to an accident or illness requiring medical care? | YES | NO |
| 9. Has injury or illness prevented your child from exercise or other athletic activities?   | YES | NO |
| 10. Is your child taking medicine or under a physician's care at this time?   | YES | NO |
| 11. Has your child experienced any feelings of faintness, dizziness, or fatigue after exercise or exertion?   | YES | NO |
| 12. Has there been any change in vision, such as wearing glasses or contact lenses?   | YES | NO |
| 13. Has your child developed any allergies?   | YES | NO |
| 14. Females Only: Is your child's menstrual cycle regular or absent? _____  |     |    |
| 15. Describe the condition or situation that caused any questions listed above to be answered "YES".  |     |    |

"Yes" to any of these questions does not mean automatic disqualification from an interscholastic activity. However, it will require the signature/stamp of your private physician plus a review and approval by the school physician before the student can report to practice tryout and receive clearance participation.

Note: This person is in satisfactory condition and may engage in all school sports activities except as noted.

Signature/Stamp of Private Physician \_\_\_\_\_ Date \_\_\_\_\_  
 School Physician \_\_\_\_\_ Date \_\_\_\_\_

Comments:

**PARENT CONSENT MUST BE SIGNED BELOW**

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate in the interscholastic athletic activity listed below. All answers are correct as of this date. I hereby give my consent for

\_\_\_\_\_  
 Name of Student

To participate in \_\_\_\_\_ practices and contests.  
 Sport Activity

DATE: \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

Home telephone Number(s) \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Telephone Number(s) \_\_\_\_\_ Beeper \_\_\_\_\_