

GREAT NECK PUBLIC SCHOOLS
Health Services
Interscholastic Sports Health History Update "B" Form

NAME _____ DATE of BIRTH _____ M / F _____ GRADE _____

TO PARTICIPATE IN INTERSCHOLASTIC SPORTS THE STUDENT MUST SUBMIT TO THE NURSE:

Physical Exam * The exam date must be within one year to the start of the sport season

"B" FORM {Health history UPDATE Form → Signed by Parent/Guardian}

- **Each New Sport Season** requires a "B" Form.
- **This "B" Form must be dated & returned to the Nurse NO earlier than 30 Days prior to the start of EACH sport season**

Health History To Be Completed By Parent/Guardian *Answer questions below to indicate if your child has or has ever had the following.*

Provide details to any Yes answer on lines below:	Y E S	N O
Ever been restricted by a doctor or nurse practitioner from sports participation for any reason?		
Have an ongoing medical condition? Please check below: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell Trait or Disease <input type="checkbox"/> Other		
Ever had surgery?		
Ever spent a night in the hospital?		
Have a life threatening allergy? <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> Other		
Carry an Epinephrine Auto-Injector?		
Ever passed out during or after exercise?		
Ever complained of light headedness or dizziness during or after exercise?		
Ever complained of chest pain, tightness, or pressure during or after exercise?		
Ever complained fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has student ever had a test for their heart? (i.e. EKG, echocardiogram, stress test)		
Ever been told they have a heart condition or problem?		
Ever had high or low blood pressure?		
Ever complain of getting more tired or short of breath than his/her friends during exercise?		
Wheeze or cough frequently during or after exercise?		
Ever been told by their health care provider they have Asthma? <input type="checkbox"/> Use or carry an inhaler or Nebulizer?		
Ever become ill while exercising in hot weather?		
On a special diet or have to avoid certain foods?		
Have to worry about their weight?		
Have stomach problems?		

Provide details to any Yes answer on lines below:	Y E S	N O
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion or been told s/he had a concussion		
Ever have headaches with exercise?		
Ever had a seizure?		
Currently being treated for a seizure disorder or epilepsy?		
Ever been unable to move his/her arms & legs, or had tingling, numbness or weakness after being hit or falling?		
Ever had an injury, pain or swelling of joint that caused them to miss practice or a game?		
Use a brace, orthotic or other device?		
Have any problems with their hearing or wear hearing aids?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Have any problems with their vision or have vision in one eye only?		
Wear glasses or contacts?		
Ever had a hernia?		
Does s/he have only one (1) functioning kidney?		
Does s/he have a bleeding disorder?		
Did s/he have a fracture or break since last physical exam?		
Females Only: Has she had her period? ____ At what age did it begin? ____ How often does she get her period ____? Last Menstrual Period ____		
Males Only: Does He only have one (1) testicle?		
Family History: 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?		
Has any relative died suddenly before the age of 50 from an unknown or heart related cause?		

(continue on back if necessary)

I certify that to the best of my knowledge my answers are complete and true.
I have reviewed the above information & give permission for my child to participate in
SPORT _____
Parent/Guardian Signature: _____ Date: _____

CLEARED FOR: _____
 School Nurse _____ Date _____ **Date of Physical** _____