Stafford Middle School/Plattsburgh High School

Interval Health History for Athletics, New Students and 7th, 9th and 11th Grade Mandated Physicals

Both pages must be completed

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐ 9 ☐ 10 ☐ 11 ☐ 12	Level (check): ◯ JV ◯ Varsity
Sport:	Limitations: ◯ Yes ◯ No
Date of last health exam:	Date form completed:

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.

Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:

General Health Concerns	Yes	No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?	◯	◯
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait/disease ☐ Other		
3. Ever had surgery?	◯	◯
4. Ever spent the night in a hospital?	◯	◯
5. Been diagnosed with Mononucleosis within the last month?	◯	◯
6. Have only one functioning kidney?	◯	◯
7. Have a bleeding disorder?	◯	◯
8. Have any problems with his/her hearing or wears hearing aid(s)?	◯	◯
9. Have any problems with his/her vision or has vision in only one eye?	◯	◯
10. Wear glasses or contacts?	◯	◯
Allergies	**Yes**	**No**
11. Have a life threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?	◯	◯
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	◯	◯
14. Wheeze or cough frequently during or after exercise?	◯	◯
15. Ever been told by their health care provider they have asthma?	◯	◯
16. Use or carry an inhaler or nebulizer?	◯	◯

Has/Does your child:

Concussion/ Head Injury History	Yes	No
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	◯	◯
18. Have you ever had a head injury or concussion?	◯	◯
19. Ever had headaches with exercise?	◯	◯
20. Ever had any unexplained seizures?	◯	◯
21. Currently receive treatment for a seizure disorder or epilepsy?	◯	◯
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?	◯	◯
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.	◯	◯
24. Wear protective eyewear, such as goggles or a face shield?	◯	◯
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	◯	◯
Females Only	**Yes**	**No**
26. Begun having her period?	◯	◯
27. Age periods began:		
28. Have regular periods?	◯	◯
29. Date of last menstrual period:		
Males Only	**Yes**	**No**
30. Have only one testicle?	◯	◯
31. Have groin pain or a bulge or hernia in the groin?	◯	◯

Has/Does your child:

Heart Health	Yes	No
32. Ever passed out during or after exercise?	○	○
33. Ever complained of light headedness or dizziness during or after exercise?	○	○
34. Ever complained of chest pain, tightness or pressure during or after exercise?	○	○
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	○	○
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?	○	○
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		

Injury History	Yes	No
38. Ever been diagnosed with a stress fracture?	○	○

Injury History *continued*	Yes	No
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	○	○
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	○	○
41. Have a bone, muscle, or joint injury that bothers him/her?	○	○
42. Have joints become painful, swollen, warm, or red with use?	○	○

Skin Health	Yes	No
43. Currently have any rashes, pressure sores, or other skin problems?	○	○
44. Have had a herpes or MRSA skin infections?	○	○

Stomach Health	Yes	No
45. Ever become ill while exercising in hot weather?	○	○
46. Have a special diet or have to avoid certain foods?	○	○
47. Have to worry about his/her weight?	○	○
48. Have stomach problems?	○	○
49. Have you ever had an eating disorder?	○	○

Mental Health	Yes	No
50. Has your child experienced any emotional issues? Stress, Anxiety, Depression? _____	○	○

Medications:_____

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known:

_____

_____

_____

I certify to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature:_____Date: _____

Please indicate (√) if you prefer your child to have a school physical or private physical exam ○ School Physical ○ Private Physical

The Plattsburgh City School District has implemented a Concussion Management Plan in accordance with the Concussion Management and Awareness Act. Any student who has sustained, or believed to have sustained a head injury in or out of school will be removed from play. Students will need to **complete a return to play process with clearance from the School Physician** in order to return to full physical participation in school athletic activities. Computerized neurocognitive baseline testing will be used as an assessment tool in concussion management. Further information is available through the PCSD website and by contacting your student's school nurse. Parent permission for student participation in the PCSD Concussion Management Plan:

Parent/Guardian Signature: _____ Date: _____

I authorize the school nurse to share pertinent information regarding my child's health with only the involved staff of Plattsburgh High School and the student's primary care physician. This authorization shall remain in effect for this school year.

Parent/Guardian Signature_____ Date: _____

This form reviewed by: _____ ***School Nurse*** ***Date:*** _____

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Plattsburgh City School District
Stafford Middle School/Plattsburgh High School

DEVELOPMENTAL HISTORY

(to be completed for new students)

STUDENT NAME: _____ DOB: _____ GRADE/TEACHER: _____

PREGNANCY INFORMATION:

Mother's Age during pregnancy: _____ Length of Pregnancy (in weeks): _____

CONCERNS DURING PREGNANCY (check any that apply)

☐ Infection ☐ Bleeding ☐ High Blood Pressure ☐ Anemia ☐ Trauma
☐ Inherited Disease ☐ Medication (other than iron, vitamins) ☐ Chronic Disease
☐ Hospitalization ☐ Swelling ☐ Other _____

LABOR AND DELIVERY:

Length of labor: _____ hours

Delivery complications (check all that apply)

☐ Cesarean ☐ Forceps ☐ Breech ☐ Slowed heartrate

Anesthesia/medications given during delivery? ◯ No ◯ Yes _____

NEONATAL:

Birth Weight: ____lbs ____oz

COMPLICATIONS (check any that apply)

☐ Breathing problems ☐ Infection ☐ Rh factor
☐ Birth defects ☐ Feeding concerns ☐ Needed incubator
☐ Needed oxygen ☐ Blue spells ☐ Convulsions
☐ Jaundice ☐ Other _____

DEVELOPMENTAL MILESTONES:

How did child meet developmental milestones, compared to brothers, sisters, peers?

Sitting alone	◯ Faster	◯ Slower	◯ Equal
Talking	◯ Faster	◯ Slower	◯ Equal
Toilet Training	◯ Faster	◯ Slower	◯ Equal
Walking	◯ Faster	◯ Slower	◯ Equal

Has your child received: ☐ Speech ☐ Occupational therapy ☐ Physical Therapy
☐ Counseling ☐ Special Education Services

Describe any developmental concerns: _____

Signature of Parent/Guardian: _____ Date: _____