ESM Interval Health History and Consent for Sports – Page One

Both pages MUST be completed by a **Parent/Guardian ONLY** and **PRIOR TO EACH SEASON** (Fall, Winter and Spring) that your child would like to participate in. Forms will be accepted at the nurse's office 2 weeks prior to each sports start date. Please explain all yes answers, **ALL boxes MUST BE CHECKED** and **incomplete forms will not be accepted.**

Student Name: _____ DOB: _____

Date: _____ Grade: _____ Sport: _____

Level: JH ☐ JV ☐ Varsity ☐ Any Limitations: _____

** **ANY medications** (including over the counter) to be taken at practice and/or athletic event **will require the proper paperwork on file in the nurse's office**. **

Contact the school nurse at (631) 801 – 3262 with any 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. Had any injuries in which they received medical attention SINCE THEIR LAST PHYSICAL EXAM?		
3. Had any serious illness or an illness lasting more than five days SINCE THEIR LAST PHYSICAL EXAM?		
4. Have any ongoing medical condition? ☐ Asthma ☐ Pneumonia ☐ Bronchitis ☐ Diabetes ☐ Seizures ☐ Other _____		
5. Ever had surgery?		
6. Been admitted to the hospital or treated in the Emergency Room SINCE THEIR LAST PHYSICAL EXAM?		
7. Been diagnosed with Mononucleosis within the last month?		
8. Have only one functioning kidney?		
9. Have any issues with his/her bladder?		
10. Have a bleeding disorder?		
11. Have any problems with his/her hearing, ears or wears hearing aid(s)?		
12. Have any problems with his/her vision, eyes or has vision in only one eye?		
13. Wear glasses or contacts?		
14. Have any problems with his/her nose, throat, teeth/mouth?		
15. Have been diagnosed with Diabetes? If yes, contact the nurse's office at (631) 801 – 3262.		
Allergies	**Yes**	**No**
16. Have a life-threatening allergy? Check all that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other _____		
17. Carry an Epinephrine auto-injector? If yes, you MUST have medical orders on file with the nurse's office.		
Family History	**Yes**	**No**
18. Have any relative who has been diagnosed with a heart condition?		

Has/Does Your Child:		
Concussion/Head Injury History	**Yes**	**No**
19. Ever had a hit to the head that caused headache, dizziness, nausea, confusion or been told he/she had a concussion?		
20. Ever had a head injury or concussion with or without the loss of consciousness? If yes, provide dates and specific details. _____ _____ _____ _____ _____ _____		
21. Ever had headaches with exercise?		
22. Ever had any unexplained seizures?		
23. Currently receive treatment for a seizure disorder or epilepsy?		
24. Require the medication DIASTAT? If yes, contact the nurse's office at (631) 801 – 3262.		
Injury Health	**Yes**	**No**
25. Ever been diagnosed with a stress fracture?		
26. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
27. Ever had an injury, pain, or swelling of joints that caused him/her to miss practice or a game?		
28. Have bone, nerve, muscle or joint injury that bothers him/her?		
29. Have joints become painful, swollen, warm or red with use?		
Devices/Accommodations	**Yes**	**No**
30. Use a brace, orthotic or other device?		
31. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag.)?		
32. Wear protective eyewear, such as goggles or a face shield?		
Stomach Health	**Yes**	**No**
33. Ever become ill while exercising in hot weather?		
34. Have a special diet or have to avoid a certain type of food?		
35. Have to worry about his/her weight?		
36. Have stomach or digestive issues?		
37. Ever had an eating disorder?		

ESM Interval Health History and Consent for Sports – Page Two

Has/Does Your Child:		
Heart Health	**Yes**	**No**
38. Ever passed out during or after exercise?		
39. Ever complained of lightheadedness or dizziness during or after exercise?		
40. Ever complained of chest pain, tightness or pressure during or after exercise?		
41. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
42. 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 ☐ Kowasaki Disease ☐ Low Blood Pressure ☐ High Cholesterol ☐ Rheumatic Fever ☐ Costochondritis Pain ☐ Other _____		
43. Ever had a test by their medical provider for his/her heart (e.g.EKG or electrocardiogram stress test)?		

Has/Does Your Child:		
Breathing (Respiratory) History	**Yes**	**No**
44. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
45. Ever wheeze or cough during or after exercise?		
46. Ever been told by their health care provider they have Asthma?		
47. Use or carry an Inhaler or nebulizer? If yes, you MUST have medical orders on file with the nurse's office.		
Females Only	**Yes**	**No**
48. Begun having her menstrual period?		
49. Have any abdominal pain?		
Males Only	**Yes**	**No**
50. Have only one testicle?		
51. Have groin pain, bulge or hernia in the groin?		
Skin Health	**Yes**	**No**
52. Currently have any rashes, pressure sore or other skin problems?		
53. Have had a herpes or MRSA skin infection?		

- Is your child currently taking any medications or are they under the care of a physician at this time? ☐ Yes ☐ No
- Is there any reason your child cannot participate in a sport at this time? ☐ Yes ☐ No

USE THE LINES BELOW TO EXPLAIN IN DETAIL ALL QUESTIONS MARKED YES:

_____

_____

_____

_____

- I hereby give permission for my child to participate in the Eastport /South Manor Interscholastic Athletic Program.
- I understand that participating in an interscholastic athletic or related activity may place my child at a risk for injury.
- I hereby give permission for my child to travel to away games and/or meets under the supervision of a coach.
- I will assume the responsibility for any unreturned equipment loaned to my child.
- Consequent expenses, in excess of applicable insurance payments are the sole responsibility of the parent/guardian.
- I hereby give permission for my child to engage in all physical education/athletic activities while wearing his/her contact lenses and/or orthodontic appliance. I understand these materials can be lost, crushed or damaged during body contact activities and vigorous exercise. I recognize that it is my responsibility to replace any personal items damaged or lost.
- I am aware it is the responsibility of my child to carry any needed medications, kits and snacks and that the **proper paperwork is on file with the nurse's office**. (631) 801 – 3262.
- In the event of an EMERGENCY and I cannot be reached, I consent for my child to receive medical care.
- I hereby state that, to the best of my knowledge and belief, my answers to the above questions are correct in regard to my child _____.

EMERGENCY CONTACT INFORMATION

Name:	**Home Phone #**	**Work Phone #**	**Cell Phone#**
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature _____ Date _____

Relationship to Student _____