Island Trees UFSD PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY –

Health History And Parent Permission To Be Completed By Parent/Guardian

COMPLETE AND RETURN TO THE SCHOOL NURSE NO MORE THAN 30 DAYS PRIOR TO THE START OF EACH SPORT

Student Name: _____ Grade_____ DOB: ____/____/_____

Parent Name_____ Home Phone_____ Cell_____

I hereby give my son/daughter permission to engage in interscholastic athletics as a member of the _____ team. I further understand that participation in athletics could lead to serious or, in certain cases, fatal injury. The answers below are correct as of this date and he/she has my permission to participate. Please note this information is shared with Coaches and Athletic Office. **In addition, I have read the information on the back side of this form that pertains to Concussions.**

Parent or Guardian Signature_____ Date____/____/____

Health office use only

Date of last health exam: ____/____/____ Nurses signature_____ Date _____

Health Limitations: ❑ Yes ❑ No

Answer questions below to indicate if your child has or has ever had the following and provide details:

Question	YES	NO
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: Asthma Diabetes Seizures Other Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have a life threatening allergy? Please check below: Medication Food Insect bites Pollen Latex Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Does s/he worry about their weight?		

Question	YES	NO
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aides?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin?_____		
How often does she get her period?		
Date of last menstrual period_____		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
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 unknown or heart related cause?		

What is a concussion?
A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.
Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

What are the signs and symptoms of a concussion?
You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.
If your child or teen reports *one or more* of the symptoms of concussion listed below, or if you notice the symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

SIGNS OBSERVED BY PARENTS OR GUARDIANS	SYMPTOMS REPORTED BY YOUR CHILD OR TEEN	
◦Appears dazed or stunned ◦Is confused about events ◦Answers questions slowly •Repeats questions •Can't recall events *prior* to the hit, bump, or fall ◦Can't recall events *after* the hit, bump, or fall •Loses consciousness (even briefly) •Shows behavior or personality changes ◦Forgets class schedule or assignments	Thinking/Remembering: ◦Difficulty thinking clearly ◦Difficulty concentrating or remembering •Feeling more slowed down •Feeling sluggish, hazy, foggy, or groggy Physical: •Headache or "pressure" in head •Nausea or vomiting •Balance problems or dizziness •Fatigue or feeling tired •Blurry or double vision •Sensitivity to light or noise •Numbness or tingling ◦Does not "feel right"	Emotional: ◦Irritable ◦Sad •More emotional than usual ◦Nervous Sleep*: ◦Drowsy •Sleeps *less* than usual •Sleeps *more* than usual •Has trouble falling asleep

Children and teens with a concussion should **NEVER** return to sports or recreation activities on the same day the injury occurred. They should delay returning to their activities until a health care professional experienced in evaluating for concussion says they are symptom-free and it's OK to return to play. This means, until permitted, not returning to:

- Physical Education (PE) class,
- Sports practices or games, or
- Physical activity at recess.

RETURN TO SCHOOL ACTIVITIES

The following is a recommended sample return to physical activity protocol based on the Zurich Progressive Exertion Protocol: http://sportconcussions.com/html/Zurich%20Statement.pdf

Phase 1- low impact, non-strenuous, light aerobic activity such as walking or riding a stationary bike. If tolerated without return of symptoms over a 24 hour period proceed to;

Phase 2- higher impact, higher exertion, and moderate aerobic activity such as running or jumping rope. No resistance training. If tolerated without return of symptoms over a 24 hour period proceed to;

Phase 3- Sport specific non-contact activity. Low resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;

Phase 4- Sport specific activity, non-contact drills. Higher resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;

Phase 5- Full contact training drills and intense aerobic activity. If tolerated without return of symptoms over a 24 hour period proceed to;

Phase 6- Return to full activities without restrictions.

Information obtained from:
U.S. Department of Health and Human ServicesCenters for Disease Control and Prevention
AND www.nyshsaa.org and refer to New Concussion Law