

## Jordan-Elbridge CSD Mandatory Sports Health Review

New York State Education Law requires that a **health history** be conducted for each athlete at the beginning of each sport season, prior to the start of try-outs or practice sessions unless the athlete received a full medical examination within 30 days of the start of the season.

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Student Name	Age	Grade	Sport
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Date of last Sports Physical: \_\_\_\_\_ Completed By: \_\_\_\_\_



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| 1. Has the student suffered any injuries requiring medical attention?                                    | Yes | No |
| 2. Has the student been absent from school five or more consecutive days due to illness or injury?       | Yes | No |
| 3. Is the student presently on medication or under a physicians care                                     | Yes | No |
| 4. Does the student have any feeling of faintness, dizziness or fatigue after exercise or exertion?      | Yes | No |
| 5. Has the student had any vision changes (wearing glasses/contacts)?                                    | Yes | No |
| 6. Has the student had any operations or fractures?  | Yes | No |
| 7. Has the student developed any allergies (bee stings) or asthma?                                       | Yes | No |
| 8. Does the student have any chronic diseases (Diabetes, Heart, respiratory or other)?                   | Yes | No |
| 9. Has the student suffered any concussions?   | Yes | No |
| 10. Has a physician ever recommended that there be limits placed on participation in competitive sports? | Yes | No |

*In the space below, please describe the condition or situation that caused you to answer "yes" to any of the questions above. Please indicate month/date/year and students age at time of illness, injury or surgery.*

*I understand that these questions are asked in order to decide if the student is in proper physical condition to participate in the sport indicated. I also understand that for the health, safety and well being of my child, the information contained herein may be shared with the Director of Athletics, Jordan-Elbridge Coaching Staff and/or Emergency Responders.*

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Parent/Guardian Signature	Date
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Participation: <input type="checkbox"/> Approved <input type="checkbox"/> Referred to School Physician	_____	_____
	School Health Office Signature	Date
School Physician Review: <input type="checkbox"/> Qualified <input type="checkbox"/> Disqualified	_____	_____
	School Health Office Signature	Date