Sandusky City Schools

HEALTH HISTORY /NURSE INTERVIEW FORM

For Grades Six through Twelve

To be completed by parent or guardian.

Please print or type

Student's Name____ Date__________________
Last First Middle

School____ Grade______ Sport__________________

1. Has your child ever sustained an injury which prevented him/her from playing sports for more than one day?
If so, please check all areas.

____Concussion/Loss of Consciousness
____Other Head Trauma
____Serious Neck Trauma
____Arm/Finger Numbness or Weakness
____Back Injury
____Broken Bone/Fracture
____Dislocated (out of place) Joint
____Deep Muscle Bruise
____Pulled Muscle, Ligament, Sprain
____Frequent Knee Pain
____Heat Exhaustion
____Other__________________

If you checked any of the above, please explain and include date of injury:______________________________

2. Does your child have a history of:

____Asthma/Wheezing
____Arthritis
____Heart Murmur
____Chest Pain/Irregular Heart Beat
____Rheumatic Fever
____High Blood Pressure
____Diabetes
____Fainting
____Seizures
____Hepatitis/Yellow Jaundice
____Mononucleosis
____Anemia
____Blood Disorder
____Sickle Cell Disease
____Hernia/Rupture
____Skin Disease/Boils/Rash
____Operations/Surgery
____Mental/Emotional Problems
____Hyperactivity/Attention Deficit Disorder
____Hypoglycemia/Low Blood Sugar
____Other__________________

If you checked any of the above, please explain:______________________________

3. Is there any family history of medically unexplained or cardiac caused sudden death under age 50? ____Yes ____No
If yes, please explain:______________________________

4. If your child is taking medication on a regular basis, please list medication and dosage:______________________________

5. Please list and describe allergies and reactions to:______________________________
Medicine/Drugs:______________________________
Food/Plants/Other:______________________________
Recommended treatment if allergy is severe?______________________________

6. When did your child last see a doctor? Date______________ Doctor's Name______________________
Reason______________________________

7. While exercising, has your child ever had chest pain, light-headedness, fainting, or an irregular heart beat? ____Yes ____No
If yes, please explain:______________________________

8. Females only: Is your daughter pregnant? ____Yes ____No Date of most recent menstrual period:______________

Please check one and sign below.

Parent/Guardian Consent

____I give consent for a screening physical examination for my child to be given by the school physician on school premises.

____My child will have a physical examination by the family physician, MD, DO, CNP, or PA.

By signing this, I give permission to school personnel to share my child's health /medical concerns, past and present, with school personnel on an "as need to know" basis, unless I notify the school nurse in "writing" that I do not want it shared. We consent to the participation of the above named student in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by the physician(s) designated by school authorities. We have read and understand the OHSAA Athletic Eligibility Information Bulletin.

Date__________ Parent/Guardian Signature______________________ Student Signature______________________

Daytime Phone______________ Cell Phone/alternate means of contact______________________

NOTE: History and Consent MUST be completed prior to physical examination.

To be completed by physician:

PHYSICAL EXAMINATION (Please print or type)

Student's Name____ Birth Date_______________________
Last First Middle

Sport______________________________ Height__________ Weight__________ BP_____/_____ Pulse__________

MEDICAL	**Normal**	**Abnormal Findings**	**Initials**
Eyes/Ears/Nose/Throat	_______	__________	_______
Lymph Nodes	_______	__________	_______
Heart	_______	__________	_______
Pulses	_______	__________	_______
Lungs	_______	__________	_______
Abdomen	_______	__________	_______
Genitalia (males only)	_______	__________	_______
Skin	_______	__________	_______

MUSCULOSKELETAL	**Normal**	**Abnormal Findings**	**Initials**
Neck	_______	__________	_______
Back	_______	__________	_______
Shoulder/Arm	_______	__________	_______
Elbow/Forearm	_______	__________	_______
Wrist/Hand	_______	__________	_______
Hip/Thigh	_______	__________	_______
Knee	_______	__________	_______
Leg/Ankle	_______	__________	_______
Foot	_______	__________	_______

CLEARANCE

____Cleared for Contact Sports **____Cleared for Non-Contact Sports**

____Cleared after completing evaluation/rehabilitation for:_________________________________
____
____
____

____ Not cleared for: ________________________ **Reason:**______________________________

Recommendations: ____
____
____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (note exceptions above).

______________________________________ ______________________________________

Physician's Name (MD or DO) and Address (stamp or print) **Examiner's Signature**

______________________________________ ______________________________________

If the Physician's Assistant (P.A.) or Certified Nurse Practitioner (C.N.P.) performed the examination, please stamp or print the name and address of the collaborating physician or physician group.

Date of Examination

NOTE: History and Consent MUST be completed prior to physical examination.