



**HARRISON CENTRAL SCHOOL DISTRICT  
HARRISON, NEW YORK 10528  
Department of Physical Education, Health and Athletics  
ATHLETIC HEALTH HISTORY UPDATE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**SCHOOL** \_\_\_\_\_ **GRADE** \_\_\_\_\_ **SPORT** \_\_\_\_\_

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**Note to parents:** As required by the New York State Education Department, a physical exam is performed annually in order for a student to participate in interscholastic athletics. For each new season, the parent and student are required to complete the Athletic Health History Update. It will be reviewed by the school nurse and referred to the school physician if necessary. The school physician will determine whether further evaluation is required.

**Note to School Nurses:**

- A. A student should not be cleared if there has been an absence of >5 days unless the illness was not sports related and will not compromise the student's participation. Notes from the family physician may be necessary.
- B. Sports related injuries require clearance notes from a physician.
- C. In unclear situations, schedule the students for re-examination.

**MEDICAL HISTORY**

**For any YES response, please explain:**

1. How many days have you been absent since participating in your last sport? \_\_\_\_\_ days  
Reason: \_\_\_\_\_
2. Have you had any illnesses since participating in your last sport? Yes [ ] No [ ]  
Describe: \_\_\_\_\_
3. Have you had any accident or injury during or since participating in your last sport? Yes [ ] No [ ]  
Describe: \_\_\_\_\_
4. Have you visited your doctor or an emergency room for any reason since participating in your last sport? Yes [ ] No [ ]  
Describe: \_\_\_\_\_
5. Are you taking any medication? Yes [ ] No [ ]  
List: \_\_\_\_\_
6. During participation in your last sport, have you gotten unusually out of breath, had chest pains, headaches, palpitations or dizziness? Yes [ ] No [ ]  
Describe: \_\_\_\_\_
7. Have you ever fainted during exercise? Yes [ ] No [ ]
8. Is there any additional health information that you feel the school medical team should know about? Yes [ ] No [ ]  
Describe: \_\_\_\_\_

I have read the above information and, to the best of my knowledge, I have answered the questions truthfully.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**FOR HEALTH OFFICE USE ONLY:**

[ ] Approved for participation

[ ] Referred to School Physician \_\_\_\_\_

School Nurse

Date