OYSTER BAY - EAST NORWICH CENTRAL SCHOOL DISTRICT
HEALTH SERVICES

INTERIM HEALTH FORM

_____ _____
Student's Name Grade

TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: **"YES"** to any of these questions does not mean automatic disqualification from the athletic activity indicated below. However, it will require a review and approval by the medical office before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL

The initial examination that you received for participation in the interscholastic athletic program is valid for competition for a period of 12 continuous months from the date of examination. However, your medical history must be updated in a new sports season.

1. Any injuries requiring medical attention? _____YES _____NO
2. Any Illness more than five (5) days? _____YES _____NO
3. Taking medicine or under physician's care at this time? _____YES _____NO
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? _____YES _____NO
5. Change in wearing glasses or contact lens? _____YES _____NO
6. Any surgical operations or fractures? _____YES _____NO
7. Any treatment in a hospital or emergency room? _____YES _____NO
8. Developed any allergies? _____YES _____NO
9. Any chronic disease? _____YES _____NO
10. Use an inhaler? Specify Type_____ _____YES _____NO
11. Have you ever had a concussion? If yes when _____ _____YES _____NO

DESCRIBE THE CONDITION OR SITUATION THAT CAUSED ANY QUESTIONS TO BE ANSWERED ***"YES"***.

_____
_____
_____

I, the undersigned, have read the above questions and have answered them accurately to the best of my knowledge.

_____ _____
Sport Student's Signature

_____ _____
Date Parent/Guardian Signature