Bethlehem Central School District Sports Update Form

This form MUST BE COMPLETED WITHIN 30 DAYS PRIOR TO THE START of the sport's season.

THIS FORM IS DUE TO THE HEALTH OFFICE ON OR AFTER:

Student Name:	DOB:
Select School: ☐ **Middle School** ☐ **High School**	Age:
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Level (check): ☐Modified ☐Fresh ☐JV ☐Varsity
Sport:	Limitations: ☐Yes ☐No

Health History To Be Completed By Parent/Guardian,

***Provide Date in "YES" column & Details To Any "Yes" On the Back of this Form.**

Any medications to be taken at practice/events will require paperwork; contact school health office

Has/Does your child:		
General Health Concerns	**Yes**	**No**
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason within last 12 months?		
2. **Have an ongoing medical condition?** ☐ **Asthma** ☐ **Diabetes** ☐ **Seizures** ☐ **Other**		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies	**Yes**	**No**
11. **Have a life threatening allergy?** Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. **Carry an epinephrine auto-injector?**		
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		
16. **Use or carry an inhaler or nebulizer?**		

Has/Does your child:		
Concussion/ Head Injury History	**Yes**	**No**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	**Yes**	**No**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	**Yes**	**No**
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

Student Name:

Has/Does your child:		
Heart Health	**Yes**	**No**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History *continued*	**Yes**	**No**
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	**Yes**	**No**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a MRSA infection?		
Stomach Health	**Yes**	**No**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or have to avoid certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Ever had an eating disorder?		

Please explain fully any question you answered "YES" to in the space below:

Your child's last physical on file at school is _____/_____/_____: therefore, your child's physical is:

☐ **OUTDATED.** Your child ***needs an updated physical*** by your child's primary care provider ***before sport tryouts begin.*** Please provide a copy of the student's updated physical to the Health Office when completed. *Physical forms can be found on District's website.*

☐ **CURRENT:** Your child's physical requirement has been met.

PARENT/GUARDIAN: Please read the following statements and provide your signature. If you have any questions, please contact your child's Health Office.

☐ To my knowledge, there is no medical reason that my son/daughter cannot participate in interscholastic sports.

☐ I understand that the physical exam ***and*** the sport's update form (*as well as current medication order(s), if applicable*), **MUST be submitted to the school health office by the noted DUE DATE of:_____,2018 ;** and that failure to do so will result in my child not being able to participate in the involved sport until such time they are received and reviewed.

☐ I am aware that the District has a Concussion Protocol and that I can access information regarding Head Injuries and Concussions on the District's "Athletics" link: http://www.bethlehemschools.org/departments/athletics/

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

PHONE:_____EMAIL:_____