

The Berkeley Carroll School

Pre-Participation/Interval Athletic History

Prior to the start of the each sport season, a health history review for each student-athlete must be conducted by their parent/guardian (this form does not require a doctors signature).

Date: ___/___/___

Student Name: _____

Date of Birth: ___/___/___

Level: Varsity/Junior Varsity
 Middle School

Age: _____

Grade: _____

Sport: _____

Limitations: Yes
 No

THE FOLLOWING MUST BE COMPLETED BY PARENT OR GUARDIAN

Answer questions below to indicate if your child has ever had the following and provide details to any yes answer on the lines below. (NOTE: A "YES" response to any of these questions does not mean automatic disqualification from activity. However, it may require a review and approval by a physician before the student can participate.)

Question	YES	NO
Has a doctor of nurse practitioner (a healthcare provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell Trait <input type="checkbox"/> Other		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Has s/he had any illness lasting more than (5) days?		
Does s/he have a life threatening allergy? Please check below: <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> Insect bites <input type="checkbox"/> Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a healthcare provider ever ordered a test for his/her heart? (i.e. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Does s/he take any prescription medications?		

Question	YES	NO
Does s/he wheeze or cough frequently during or after exercise?		
Has a healthcare provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and leg, or had tingling, numbness, or weakness after being hit or falling		
Has/he ever had an injury, pain or swelling of a joint that caused him/her to miss a practice or game?		
Does s/he use a brace, orthotic or device?		
Does she/he have any problems with his/her hearing or wear hearing aides?		
Does s/he have any problems with his/her vision or only have vision in one eye?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he only have 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Does s/he have any chronic disease?		

Please explain fully any question you answered yes to in the space below. (Please print clearly, and provide dates if known):

PARENTAL PERMISSION:

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team stated at the top of this form. I certify to the best of my knowledge my answer are complete and true and s/he has my permission to participate.

SIGNED: _____ DATE: _____