



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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Concussion/Loss of Consciousness | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Pulled Muscle, Ligament, Sprain |
| <input type="checkbox"/> Other Head Trauma | <input type="checkbox"/> Broken Bone/Fracture | <input type="checkbox"/> Frequent Knee Pain |
| <input type="checkbox"/> Serious Neck Trauma | <input type="checkbox"/> Dislocated (out of place) Joint | <input type="checkbox"/> Heat Exhaustion |
| <input type="checkbox"/> Arm/Finger Numbness or Weakness | <input type="checkbox"/> Deep Muscle Bruise | <input type="checkbox"/> Other _____ |

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

2. Does your child have a history of:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hernia/Rupture |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Disease/Boils/Rash |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis/Yellow Jaundice | <input type="checkbox"/> Operations/Surgery |
| <input type="checkbox"/> Chest Pain/Irregular Heart Beat | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mental/Emotional Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hyperactivity/Attention Deficit Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hypoglycemia/Low Blood Sugar |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> 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 OHSA 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
____ 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.