Chenango Valley Central School District

Medical Questionnaire

Student's Name _____ **Sex**: M / F **Age:** ___ **DOB** _____

Address _____

Phone# _____

Note: If you are planning on trying out for a sport, please indicate:

Sport: _____ **Grade** _____

Sport Note: Prior to the start of tryout sessions or practice at the beginning of each sport season, state regulations mandate that a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

If you check "Yes" to any of the below, please explain on back of this form.

Is your child currently being treated by a medical provider for the following:

	YES	NO		YES	NO
Life Threatening Allergy – **Epi Pen**	o	o	Headaches with exercise	o	o
Asthma - **Inhaler – (MD order needed)**	o	o	Blood or Bleeding Disorder	o	o
Anemia	o	o	Stomach Ulcer	o	o
Arthritis	o	o	Convulsions/Seizures	o	o
Heart Problem/Murmur-Chest pain	o	o	Injury to the Spleen	o	o
Diabetes	o	o	Elevated Blood Pressure	o	o

Does your child have any of the following? Check Yes or No.	**Yes**	**No**
•One eye or severe uncorrectable loss of vision in one or both eyes / severe hearing loss----------	☐	☐
•One kidney / One testicle ----------	☐	☐
• Fracture-Dislocation Bones/Joints that is **currently** being treated by a medical provider.	☐	☐
•Joint sprain/ligament tear/muscle pull that is **currently** being treated by a medical provider.	☐	☐
•Has your child had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x rays, or required surgery **since your last health appraisal /physical**?	☐	☐
•Is your child under medical care now or restricted by a medical provider from exercise or athletic activities for any reason? _____	☐	☐
•Has your child experienced any type of head injury or concussion **since your last health appraisal**?		
•Has your child fainted during exercise?	☐	☐
•Has there been a sudden cardiac death in a family member under the age of 50?	☐	☐
•Do you have any worries about your child's health or other questions you would like to discuss with a doctor? _____	☐	☐

•At what age did your child start her menstrual period? _____

•Please state your hospital preference _____

IMPORTANT NOTE:

I understand that if my student/athlete seeks medical evaluation, I **must provide the school written documentation from that doctor as to his/her physical restriction.** Until the health office receives this medical clearance in writing the student will not be permitted to participate in Physical Education, Sports and/or Playground.

☐ **I do not want the school physician to perform a physical examination on my student. My student will have a physical exam by his/her Private Health Care Provider.**

I agree with all of the above and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests. I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent Signature: **Date:**

Note: It is recommended that your student see their Private Health Care Provider on a routine basis, aside from the school screening

Medical History: If you checked "Yes", please explain below:

_____

_____

_____

_____

_____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of last health appraisal: ___/___/___ Impact Date: ___/___/___

Sports Participation: ___Approved ___Disqualified

Reason: _____

Signed_____ Date_____

Nurse Notes: _____