

**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**  
*MOUNT MERCY ACADEMY*

Prior to the start of tryout sessions or practice at the beginning of each season, 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.

**PART A:**

Student: \_\_\_\_\_ Age: \_\_\_\_\_

Grade (check):     9     10     11     12                      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sport: \_\_\_\_\_

Date of last health appraisal: \_\_\_\_/\_\_\_\_/\_\_\_\_    Limitations:  Yes     No

**PART B: 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 in PART A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

**HISTORY SINCE LAST HEALTH APPRAISAL:**

If the answer to any of the following questions is “YES”, in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer.

- |    |  |                           |                          |
|----|--|---------------------------|--------------------------|
| 1. | Any injuries requiring medical attention?                                  | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. | Any illness lasting more than five (5) days?                               | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. | Taking medicine or under physician’s care at this time?                    | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. | Any feeling of faintness, dizziness or fatigue after exercise or exertion? | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. | Change in wearing glasses or contact lenses?                               | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. | Any surgical operations or fractures?                                      | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. | Any treatment in a hospital or emergency room?                             | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. | Developed any allergies?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. | Any chronic disease?   | <input type="radio"/> Yes | <input type="radio"/> No |

Describe the condition or situation that caused any questions in PART B to be answered “YES”.

\_\_\_\_\_

\_\_\_\_\_

**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 named in PART A of this form. The answers are correct as of this date and she has my permission to participate.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE RETURN TO THE SCHOOL HEALTH OFFICE**

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