Interval Health History for Athletics

Student Name:	DOB:
School Name:	Age:

Grade (check): 7 n

by Parent/Guardian - Give details to any YES answers on the last page.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
BRAIN/HEAD INJURY HISTORY	**NO**	**YES**
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	☐	☐
Received treatment for a seizure disorder or epilepsy?	☐	☐
Has or had headaches with exercise?	☐	☐
Has or had migraines?	☐	☐
BREATHING	**NO**	**YES**
Complained of getting extremely tired or short of breath during exercise?	☐	☐
Used or carries an inhaler or nebulizer?	☐	☐
Has or had wheezing or coughing frequently during or after exercise?	☐	☐

Student Name:	DOB:

Student