

Interval Health History for Athletics

Student Name:

DOB:

School Name:

Age:

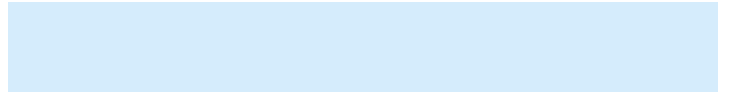
Grade (check): 7

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