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.

____Concussion/Loss of Consciousness ____Back Injury ____Pulled Muscle, Ligament, Sprain
____Other Head Trauma ____Broken Bone/Fracture ____Frequent Knee Pain
____Serious Neck Trauma ____Dislocated (out of place) Joint ____Heat Exhaustion
____Arm/Finger Numbness or Weakness ____Deep Muscle Bruise ____Other _____

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

_____

_____

2. Does your child have a history of:

____Asthma/Wheezing ____Fainting ____Hernia/Rupture
____Arthritis ____Seizures ____Skin Disease/Boils/Rash
____Heart Murmur ____Hepatitis/Yellow Jaundice ____Operations/Surgery
____Chest Pain/Irregular Heart Beat ____Mononucleosis ____Mental/Emotional Problems
____Rheumatic Fever ____Anemia ____Hyperactivity/Attention Deficit Disorder
____High Blood Pressure ____Blood Disorder ____Hypoglycemia/Low Blood Sugar
____Diabetes ____Sickle Cell Disease ____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: _____

Parent/Guardian Consent

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.

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.

Form #030-3 1215 05-14-14 revised

To be completed by physician (MD, DO, CNP, or PA.)**:**

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 for Contact Sports ____Cleared for Non-Contact Sports

____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.