Catholic Diocese of Richmond Interval Health History for Athletics

Student Name:	DOB
School Name:	Age
Grade (check): ☐ 6 ☐ 7 ☐ 8	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Brain/Head Injury History	**No**	**Yes**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

Does or Has Your Child

Breathing	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
Devices / Accommodations	**No**	**Yes**
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
Digestive (GI) Health	**No**	**Yes**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
Injury History	**No**	**Yes**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:		DOB:	

DOES OR HAS YOUR CHILD

HEART HEALTH

Ever complained of:	NO	YES
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐

DOES OR HAS YOUR CHILD

Ever been told by a health care provider	NO	YES
They have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

☐ Chest Tightness or Pain
☐ High Blood Pressure
☐ High Cholesterol
☐ New fast or slow heart rate
☐ Heart infection
☐ Heart Murmur
☐ Low Blood Pressure
☐ Kawasaki Disease
☐ Has implanted cardiac defibrillator (ICD)
☐ Has a pacemaker
☐ Other:

DOES OR HAS YOUR CHILD

FEMALES ONLY	NO	YES
Have regular periods?	☐	☐
MALES ONLY	**NO**	**YES**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
SKIN HEALTH	**NO**	**YES**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**YES**
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC) or long-COVID?	☐	☐

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems: long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50?
☐ Structural heart abnormality, repaired or unrepaired?
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

Parent/Guardian Signature:	Date:

Student Name:		DOB:	

If you answered **YES** to any questions give details. Sign and date below**.**

Parent/Guardian Signature:	Date: