Mother Seton Regional High School

One Valley Road, Clark, New Jersey 07066

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INTERIM SPORT HEALTH HISTORY QUESTIONAIRE

To be completed by the parent or guardian:

Student's Name ______________________ Age/Grade ________

Sport ______________________ Date ________

Since the last pre-participation examination, has your daughter:

1. Been medically advised not to participate in a sport? Yes ___ No ___
   If yes, describe in detail: Why?

   Is there a doctor's note to resume participation? Yes ___ No ___

2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ___ No ___
   If yes, describe in detail:

3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ___ No ___
   If yes, describe in detail:

4. Fainted or "Blacked out"? Yes ___ No ___
   If yes, describe in detail:

5. Experienced chest pains, shortness of breath, or "heart racing"? Yes ___ No ___
   If yes, describe in detail:

6. Had a recent history of fatigue and unusual tiredness? Yes ___ No ___

7. Been hospitalized, visited an emergency room or had a significant medical illness? Yes ___ No ___

8. Since the last physical, has there been a sudden death in the family or have any members of the family (under the age of 50) had a heart attack or heart trouble? Yes ___ No ___
   If yes, please explain:

9. Since your last physical, have you started taking any other ("new") medications either over the counter (OTC) or prescribed drugs by your doctor? Yes ___ No ___
   If yes, please list names of medications and dosage:

   Have any medications been stopped? Yes ___ No ___
   If yes, please list names of the medications:

10. Additional comments/explanations (please indicate to which question number the comments refer)

11. I have received and reviewed the attached "Sudden Cardiac Death in Young Athletes" brochure. Yes ___ No ___

______________________________	______________________________
Printed Name of Parent/Guardian	Signature of Parent/Guardian

School Nurse Review

____
Name of Student's Health Care Provider

______________________________	______________________________
Signature of School Nurse	Date

School District Physician Review (If Necessary)

______________________________	______________________________
Signature of School District Physician	Date