LAWRENCE PUBLIC SCHOOLS
HEALTH SERVICES

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HEALTH HISTORY UPDATE FOR SPORTS PARTICIPATION

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination by a physician within 30 days prior to the start of the season.

NAME: _____ ID #_____ DOB_____
(Please print)
SPORT:_____ SEASON: (Circle one) Fall Winter Spring

TO BE COMPLETED BY PARENT OR GUARDIAN:
Please respond to the following questions. Certain responses may require review and approval by the school physician prior to allowing the athlete to participate in the above named sport. Confidentiality of the information provided will be maintained.

1. **Within the past year has the athlete:** (If "yes", describe on line) Circle response

a. Had any injuries requiring medical attention?_____	YES	NO
b. Had any illness lasting more than five days?_____	YES	NO
c. Had any surgical procedure?_____	YES	NO
d. Had any treatment in a hospital or emergency room?_____	YES	NO
e. Felt faintness, dizziness or fatigue after exercise?_____	YES	NO
f. Passed out during or after exercise?_____	YES	NO
g. Felt any discomfort, pain or pressure in the chest during exercise?____	YES	NO
h. Felt his/her heart race or skip beats during exercise?_____	YES	NO

2. **At this time, does the athlete:** (If "yes", indicate on line)

a. Take any medication or is under doctor's care? _____	YES	NO
b. Have any chronic disease? _____	YES	NO
c. Have any allergies? _____	YES	NO
Emergency medication required? (list)_____		
d. Wear braces or other dental appliances?	YES	NO
e. Wear glasses? YES NO Wear contact lenses?	YES	NO

PARENT PERMISSION:

1. *If my child has any health condition requiring emergency medication* (e.g. asthma, allergies, diabetes) as indicated above, I will ensure that (s)he will carry medication at all team activities in order to participate. Medication authorization must be on file in the Health Office (District policy)
2. I hereby give my child permission to participate in the above named sport in the upcoming Season.

***Parent Signature*_____ *Date*_____**

AUTHORIZATION FOR PARTICIPATION;
The above named student is: ___Cleared for sports participation __Referred to School Physician
School Nurse _____ Date _____