

# Dakota Valley School District #61-8

## Pre-participation Health History

Parent/Guardian **must** complete this form **before** the physical evaluation will be given.

Name: \_\_\_\_\_ Gender: F  M  DOB: \_\_\_\_\_

Grade (Fall 2018): \_\_\_\_\_

Dakota Valley School District #61-8 requires all students who plan to participate in interscholastic activities to have on file in their school a record of satisfactory medical history and physical evaluation performed by a duly licensed Health Care Provider. This form must be completed by the PARENT or GUARDIAN and all “**Yes**” answers must be explained in the space below.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have an ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does your heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan Syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
18.	Have you had any broken or fractured bones or dislocated joints?		
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		
20.	Have you ever had a stress fracture?		
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.	Is there anyone in your family who has asthma?		
26.	Have you ever used an inhaler or taken asthma medicine?		
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28.	Have you had infectious mononucleosis (mono) within the last month?		

		Yes	No
29.	Do you have any rashes, pressure sores, or other skin problems?		
30.	Have you had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell anemia?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you unhappy with your weight?		
43.	Are you trying to gain or lose weight?		
44.	Has anyone recommended you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		
47.	Are there other sports that you would like to participate in that were not approved at a previous examination?		

**Females only:**

48.	Have you ever had a menstrual period?		
49.	How old were you when you had your first menstrual period?		
50.	How many periods have you had in the last 12 months?		

**Explain “Yes” answers here:** \_\_\_\_\_

\_\_\_\_\_

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To my best knowledge, everything is complete and correct. There are no other reasons not to qualify my child for activities. I give permission to the school or health care provider to complete a physical evaluation on my child named above.

**Date:** \_\_\_\_\_ **Parent/Guardian Signature** \_\_\_\_\_

If your son or daughter experiences pain or injury prior to, during or between activity seasons, please follow your physician’s advice for care and inform the coach / director of the concern. Permanent injury often can be prevented by early recognition and appropriate precautions.