Galway Central School Health Questionnaire and Permission Slip:

Parents and student: Please complete sections 1-3 *before* your appointment. Students without a completed permission slip and history will be unable to have an in-school health assessment

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Part 1: Permission

I give permission for my child _____ to be seen by a Galway Family Health provider on _____ for a health assessment and physical exam.

Signature: _____ Relationship to child:_____

Date:_____

Part 2: Student information

Name:_____Sex_____Age_____DOB_____

Grade_____ Sport(s)_____

Name of Parent/Guardian _____

Emergency Contact _____

Relationship to student _____ Contact number(s)_____

Physician _____Office #_____

Part 3: Health History

Medical problems….. _____

_____

Current Medications.. _____

_____

Allergies …… _____

Has your child ever been diagnosed with the following?

□ Asthma

□ Diabetes:□Type I □Type II

□ Seizure disorder

□ Serious allergic reaction to food, medicine, insect, or other

□ High cholesterol

□ High blood pressure

Please list and describe reaction: _____

_____

Part 4: Physician Review and Signature

Comment:_____

Signature: _____ Date: _____

Recommended NYSED Interval Health History for Athletics–Two Page Form Both pages must be completed.	
Student Name:	DOB:
School Name:	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	Date form completed:

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.
Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	**No**	**Yes**
1. Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?	☐	☐
4. Ever spent the night in a hospital?	☐	☐
5. Been diagnosed with Mononucleosis within the last month?	☐	☐
6. Have only one functioning kidney?	☐	☐
7. Have a bleeding disorder?	☐	☐
8. Have any problems with his/her hearing or wears hearing aid(s)?	☐	☐
9. Have any problems with his/her vision or has vision in only one eye?	☐	☐
10. Wear glasses or contacts?	☐	☐
Allergies		
11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**No**	**Yes**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	☐	☐
14. Wheeze or cough frequently during or after exercise?	☐	☐
15. Ever been told by a health care provider they have asthma?	☐	☐
16. Use or carry an inhaler or nebulizer?	☐	☐

Has/Does your child:		
Concussion/ Head Injury History	**No**	**Yes**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	☐	☐
18. Ever had a head injury or concussion?	☐	☐
19. Ever had headaches with exercise?	☐	☐
20. Ever had any unexplained seizures?	☐	☐
21. Currently receive treatment for a seizure disorder or epilepsy?	☐	☐
Devices/Accommodations	**No**	**Yes**
22. Use a brace, orthotic, or other device?	☐	☐
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	☐	☐
24. Wear protective eyewear, such as goggles or a face shield?	☐	☐
Family History	**No**	**Yes**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
Females Only	**No**	**Yes**
26. Begun having her period?	☐	☐
27. Age periods began:		
28. Have regular periods?	☐	☐
29. Date of last menstrual period:		
Males Only	**No**	**Yes**
30. Have only one testicle?	☐	☐
31. Have groin pain or a bulge or hernia in the groin?	☐	☐

Student Name:

School Name: DOB:

Has/Does your child:

Heart Health	No	Yes
32. Ever passed out during or after exercise?	☐	☐
33. Ever complained of light headedness or dizziness during or after exercise?	☐	☐
34. Ever complained of chest pain, tightness or pressure during or after exercise?	☐	☐
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	☐	☐
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	☐	☐
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		

Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	☐	☐

Has/Does your child:

Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	☐	☐
41. Have a bone, muscle, or joint injury that bothers him/her?	☐	☐
42. Have joints become painful, swollen, warm, or red with use?	☐	☐
Skin Health	**No**	**Yes**
43. Currently have any rashes, pressure sores, or other skin problems?	☐	☐
44. Have had a herpes or MRSA skin infections?	☐	☐
Stomach Health	**No**	**Yes**
45. Ever become ill while exercising in hot weather?	☐	☐
46. Have a special diet or need to avoid certain foods?	☐	☐
47. Have to worry about his/her weight	☐	☐
48. Have stomach problems?	☐	☐
49. Ever had an eating disorder?	☐	☐

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?	☐	☐
51. Was your child symptomatic?	☐	☐
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	☐	☐
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.	☐	☐
54. Was your child hospitalized? If yes, provide date(s)?	☐	☐
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	☐	☐
If yes, is your child under a HCP's care for this?	☐	☐

Please explain fully any question you answered yes to in the space below, include dates if known.
Use additional pages if necessary.

Parent/Guardian Signature: _____ Date: _____