Deposit CSD Health History Form

Student Name:	DOB:	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐ Modified ☐ JV ☐ Varsity	
Sport:	Limitations: ☐ Yes ☐ No	
Date of last health exam:	Date form completed:	

Health History MUST be Completed & signed 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 hearing or wears hearing aid(s)?	☐	☐
9. Have any problems with vision or has vision in only one eye?	☐	☐
10. Wear glasses or contacts?	☐	☐
Allergies	**No**	**Yes**
11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?	☐	☐
13. Ever had anaphylaxis?	☐	☐
Breathing (respiratory) Health	**No**	**Yes**
14. Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
15. Wheeze or cough frequently during or after exercise?	☐	☐

Breathing (respiratory) Health cont.	No	Yes
16. Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
17. Use or carry an inhaler or nebulizer?	☐	☐
Brain/ Head Injury History	**No**	**Yes**
18. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
19. Ever had a head injury or concussion?	☐	☐
20. Ever had headaches with exercise?	☐	☐
21. Ever had any unexplained seizures?	☐	☐
22. Receive treatment for a seizure disorder or epilepsy?	☐	☐
23. Ever had migraines?	☐	☐
Devices/Accommodations	**No**	**Yes**
24.Use a brace, orthotic, or other device?	☐	☐
25. 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.	☐	☐
26. Wear protective eyewear, such as goggles or a face shield?	☐	☐
Females Only	**No**	**Yes**
27. Have regular periods?	☐	☐
Males Only	**No**	**Yes**
28. Have only one testicle?	☐	☐
29. Have groin pain or a bulge, or a hernia?	☐	☐

Student Name: DOB:

Family History	No	Yes
30. 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?	☐	☐
Heart Health	**No**	**Yes**
31. Ever passed out during or after exercise?	☐	☐
32. Ever complained of light headedness or dizziness during or after exercise?	☐	☐
33. Ever complained of chest pain, tightness, or pressure during or after exercise?	☐	☐
34. Ever complained of fluttering in their chest, skipped beats, or their heart racing?	☐	☐
35. Ever had a test by a health care provider for their heart (e.g. EKG, echocardiogram stress test)?	☐	☐
36. Ever been told by a healthcare provider they have or had a heart or blood vessel problem? If so, check all that apply: ☐Heart infection ☐Chest tightness or pain ☐New fast or slow heart rate ☐Has implanted cardiac defibrillator (ICD) ☐Has a pacemaker ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:	☐	☐
Injury History	**No**	**Yes**
37. Ever been unable to move their arms or legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐
38. Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐

Injury History cont.	No	Yes
39. Have a bone, muscle, or joint injury that bothers them?	☐	☐
40. Have joints become painful, swollen, warm, or red with use?	☐	☐
41. Ever been diagnosed with a stress fracture?	☐	☐
Skin Health	**No**	**Yes**
42. Currently have any rashes, pressure sores, or other skin problems?	☐	☐
43. Have had a herpes or MRSA skin infections?	☐	☐
Digestive (GI) Health	**No**	**Yes**
44. Are there any concerns about your child's weight?	☐	☐
45. Have a special diet or need to avoid certain foods?	☐	☐
46. Have stomach or other GI problems?	☐	☐
47. Ever had an eating disorder?	☐	☐
COVID-19 Information	**No**	**Yes**
48. Has your child ever tested positive for COVID-19?	☐	☐
If No, STOP. Go to Family Heart Health History. **If Yes, answer questions below:**	☐	☐
49. Date of positive COVID test:	☐	☐
50. Was your child symptomatic?	☐	☐
51. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	☐	☐
52. Was your child hospitalized? If yes, provide date(s)? Date(s)_____	☐	☐
53. If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	☐	☐

Student Name: DOB:

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.

Parent/Guardian Signature: _____ Date: _____

If you answered **YES** to any questions, please provide details. Sign and date below.

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Parent/Guardian Signature: _____ Date:_____

Student Name: DOB: