

RECERTIFICATION FOR SPORTS PARTICIPATION

INTERIM HEALTH HISTORY

Must be completed and signed by parent or guardian

Date _____

FR/SOPH/JR/SR
(circle one)

PERSONAL INFORMATION

Name _____ Enrolled in _____ School _____

Sport _____ Age _____

Home Address _____ Phone _____

Parent/Guardian _____ Phone _____

Family Physician _____ Phone _____

Within the past year has the student had:

YES	NO	EXPLAIN
Y	N	Any injury related to sports _____
Y	N	Any injuries not related to sports _____
Y	N	Any operations _____
Y	N	Any illness requiring student to stay home or be hospitalized _____
Y	N	Experienced dizzy spells or blackouts or unconsciousness _____
Y	N	Any episodes of unexplained shortness of breath, wheezing, or chest pain _____
Y	N	Any new health problems _____
Y	N	Any new medications, prescription, or over-the-counter _____
Y	N	Any health problems student wants to discuss with a doctor _____

Parent/Guardian Signature

Date

Must be completed and signed by medical personnel performing student's recertification

Height _____ Weight _____ BP _____ / _____ Pulse _____ Handed R _____ or L _____

Clearance for sports participation:

A. Cleared

B. Cleared after completing evaluation / rehabilitation for: _____

C. Not Cleared for ___ Collision ___ Contact ___ Noncontact ___ Strenuous ___ Moderately Strenuous ___ Nonstrenuous

Due to: _____

Recommendation/Referral: _____

Name _____ of _____ Medical _____ Examiner: _____ Date: _____

Address: _____ Phone: _____

Signature MD, DO, PAC, CRNP, SNP: _____