Vernon Verona Sherrill Central School
Interval Health History

Dear Parent/Guardian:

As part of an ongoing effort to further the safety of your child, *we ask that this be filled out and returned to the coach.* Your child will receive one of these forms before each sports season. This form will be included in your son/daughter's medical record along with the original health history form.

STUDENT: _____ DATE: _____

GRADE: _____ SPORT: _____ Varsity JV Modified

To be completed by Parent/Guardian:

NOTE: "Yes" to any of these questions does not mean automatic disqualification from the sport activity. However, it will require a review and possibly written approval to continue to participate by the school or family physician.

HEALTH HISTORY since last physical:

If the answer to any of these questions is "Yes", please describe the condition or situation that prompted your answer on the back of this form.

1) Any injuries requiring medical attention?	Yes	No
2) Any illness lasting more than five days?	Yes	No
3) On medication or under physician care?	Yes	No
4) Any feeling of faintness, dizziness, or fatigue after exercise or exertion?	Yes	No
5) Change in wearing glasses or contact lenses?	Yes	No
6) Any surgical operations or fractures?	Yes	No
7) Any treatment in a hospital emergency room?	Yes	No
8) Developed any allergies?	Yes	No
9) Any chronic diseases?	Yes	No
10) Any diagnosed or suspected concussion?	Yes	No

PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate in a sports activity.

I, the undersigned, clearly understand and agree that consistent with Chapter 496 of the Laws of 2011 of the State of New York [Concussion Management Awareness Act], I will promptly inform the VVS School District of any concussions, or suspected concussions, that occur outside of school.

The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: _____

Describe the condition or situation that caused any questions to be answered “Yes”

To be completed by the school health office:

Sports Participation:

_____ Approved

_____ Referred to school physician

_____ Referred to family physician

SIGNED: _____ DATE: _____
School health office

If referred to physician:

_____ Requalified

_____ Disqualified

SIGNED: _____ DATE: _____
Physician