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SPORTS / PHYSICAL ACTIVITY
INTERIM HEALTH HISTORY

NAME______________________ SEX__________ AGE__________ DATE OF BIRTH__________

GRADE__________ SPORT/ACTIVITY______________________ DATE__________

1. Over the next 12 months, I wish to participate in the following sports ______________________

2. Have you missed more than 3 consecutive days of participation in the usual activities because of an injury this past year?
   Yes__________ No__________ (if yes, please indicate)__________
3. Have you had any broken or fractured bones or dislocated joints this past year?
   Yes__________ No__________ (if yes, please indicate)__________
4. Have you missed more than 5 consecutive days of participation in usual actives because of an illness in this past year?
   Yes__________ No__________ (if yes, please indicate)__________
5. Have you had a seizure, concussion or been unconscious for any reason in the last year?
   Yes__________ No__________
6. Have you ever passed out or nearly passed out during exercise?
   Yes__________ No__________
7. Have you ever passed out or nearly passed out after exercise?
   Yes__________ No__________
8. Have you had discomfort, pain, or pressure in your chest during exercise?
   Yes__________ No__________
9. Does your heart pound or skip beats during exercise?
   Yes__________ No__________
10. Have you had your vision checked in the past year?
    Yes__________ No__________
    Do you wear glasses or contact lenses?
    Yes__________ No__________
11. Have you had surgery or been hospitalized in the past year?
    Yes__________ No__________ (if yes, please explain)__________
    ____
12. Have any members of your family under age 50 had a heart attack, heart problem, or died unexpectedly?
    Yes__________ No__________ (if yes, please explain)__________
    ____
13. Does anyone in your family have Marfan Syndrome?
    Yes__________ No__________
14. Any changes to family health history this past year?
    Yes__________ No__________ (if yes, please explain)__________
    ____
15. Are you worried about any problems or conditions at this time?
    Yes__________ No__________ (if yes, please explain)__________
    ____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

SIGNATURE OF ATHLETE______________________ DATE__________

SIGNATURE OF PARENT______________________ DATE__________

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: ____________________ Date: ______________________

Name of Child: ________________________

		Please mark under the heading that best fits your child					
		NEVER	SOME-TIMES	OFTEN			
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:

PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present

PSC-17 may be freely reproduced.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
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Date of Birth: _____ /_____ /_____

Child's Name: ______________________________

Parent/Guardian: ______________________________

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	❒Yes ❒No	If yes, name of symptoms: ____________
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	❒Yes ❒No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	❒Yes ❒No	If yes, in what country was the child born: ____________
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	❒Yes ❒No	If yes, in what country did the child travel to: ____________
5. Have any members of the child's household come to the United States from another country?	❒Yes ❒No	If yes, name of country: ________
6. Is the child exposed to a person who: • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❒Yes ❒No	If yes, name the risk factors the child is exposed to: ____________ ____________
7. Is the child/teen in jail or ever been in jail?	❒Yes ❒No	If yes, name of jail: ________
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒Yes ❒No	If yes, name of disease or medications: ____________