

**OUR LADY OF VICTORY CATHOLIC SCHOOL  
RECERTIFICATION FOR  
ATHLETIC COMPETITION**

**INTERIM HEALTH HISTORY**

must be completed and signed by parent or guardian

Date \_\_\_\_\_

GRADE \_\_\_\_\_

**PERSONAL INFORMATION**

Name \_\_\_\_\_ Enrolled in Our Lady of Victory Catholic 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 \_\_\_\_\_