



# INTERIM QUESTIONNAIRE

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M / F  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Participation Grade: \_\_\_\_\_

## MEDICAL HISTORY

### SINCE LAST PHYSICAL EXAMINATION, HAS THIS STUDENT:

Fill in details of "YES" answers in space below:

	Yes	No
1. Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
2. Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been under a physician's care	<input type="checkbox"/>	<input type="checkbox"/>
4. Had serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
5. Had an injury requiring a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>
6. Been rendered unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
7. Been diagnosed with a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
8. Started taking any new medications?	<input type="checkbox"/>	<input type="checkbox"/>
9. Developed any new drug allergies?	<input type="checkbox"/>	<input type="checkbox"/>
10. Developed any health problems?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "YES" answers: \_\_\_\_\_  
\_\_\_\_\_

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## CONSENT FORM

(Parent or guardian and student permission and approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT \_\_\_\_\_ DATE: \_\_\_\_\_

*Note:* The original copy of this form MUST be returned to the school