

Athletic Health History

Student: _____ Grade _____ D.O.B.: _____

NO STUDENT WILL BE ALLOWED TO PARTICIPATE IN TRYOUTS, PRACTICES, OR GAMES WITHOUT A COMPLETED HEALTH HISTORY AND PHYSICAL FORM.

Health History to be Completed by Parent

Has your child ever had: (please check the appropriate circle)

	YES	NO		YES	NO
Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	Elevated Blood Pressure	<input type="radio"/>	<input type="radio"/>
Medication/Food Allergy	<input type="radio"/>	<input type="radio"/>	Orthodontic Appliances	<input type="radio"/>	<input type="radio"/>
Bee Sting Allergy	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Head Injury/Concussion	<input type="radio"/>	<input type="radio"/>
Anemia/Blood Disorder	<input type="radio"/>	<input type="radio"/>	Heart Problem/Murmur/Pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Nose Bleeds/Frequent/Severe	<input type="radio"/>	<input type="radio"/>
Bladder/Kidney Problem	<input type="radio"/>	<input type="radio"/>	Ankle Injury	<input type="radio"/>	<input type="radio"/>
Convulsions/Seizures	<input type="radio"/>	<input type="radio"/>	Neck/Back Pain/Injury	<input type="radio"/>	<input type="radio"/>
Fainting Spells	<input type="radio"/>	<input type="radio"/>	Fracture/Dislocation/Bones/Joints	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Knee Pain/Injury	<input type="radio"/>	<input type="radio"/>
Ear Problems/Hearing Loss	<input type="radio"/>	<input type="radio"/>	Serious Infections	<input type="radio"/>	<input type="radio"/>
Eye Problems/Vision Loss	<input type="radio"/>	<input type="radio"/>	Infectious Mononucleosis	<input type="radio"/>	<input type="radio"/>
Injury to the Spleen	<input type="radio"/>	<input type="radio"/>	Sudden Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>
Joint Sprain/Ligament Tear/Muscle Pull	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>	<input type="radio"/>
Contacts/Glasses for Sports	<input type="radio"/>	<input type="radio"/>	Only one testicle	<input type="radio"/>	<input type="radio"/>
Capped teeth	<input type="radio"/>	<input type="radio"/>	Menstrual Period (age began _____)	<input type="radio"/>	<input type="radio"/>

If "yes" to any of the above questions, please provide details: _____

	Yes	No
Has your child ever been unconscious or lost memory from a blow on the head?	<input type="radio"/>	<input type="radio"/>
Has your child ever fainted during exercise?	<input type="radio"/>	<input type="radio"/>
Has there ever been sudden death in a family member under 50 years of age?	<input type="radio"/>	<input type="radio"/>
Has your child been ill for 5 consecutive days?	<input type="radio"/>	<input type="radio"/>
Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation? _____	<input type="radio"/>	<input type="radio"/>
Is your child taking any medication now or in the last year?	<input type="radio"/>	<input type="radio"/>
If yes, what; _____		

I understand that this confidential information will be shared with school personnel deemed appropriate by the health professional in my child's building.

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

PARENT SIGNATURE _____ **DATE** _____