

**HOLY TRINITY HIGH SCHOOL – PARENT CONSENT/HEALTH HISTORY FORM**  
**Both pages must be completed.**

Student Name:	DOB:
School Name:	Age:
Grade (check): <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Level (check): <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity
Sport:	Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last health exam:	Date form completed:

**Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.**  
 Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other		
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been diagnosed with Mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any problems with his/her hearing or wears hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with his/her vision or has vision in only one eye?	<input type="checkbox"/>	<input type="checkbox"/>
10. Wear glasses or contacts?		<input type="checkbox"/>
Allergies		
11. Have a life-threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health		
No	Yes	
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been told by a health care provider they have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16. Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Currently receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Devices/Accommodations		
No	Yes	
22. Use a brace, orthotic, or other device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	<input type="checkbox"/>	<input type="checkbox"/>
24. Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Family History		
No	Yes	
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
Females Only		
No	Yes	
26. Begun having her period?	<input type="checkbox"/>	<input type="checkbox"/>
27. Age periods began:		
28. Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
29. Date of last menstrual period:		
Males Only		
No	Yes	
30. Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have groin pain or a bulge or hernia in the groin?	<input type="checkbox"/>	<input type="checkbox"/>