ATHLETIC HEALTH HISTORY

STUDENT NAME: _____ GRADE: _____

SCHOOL NAME: _____ DATE OF BIRTH: _____

Participation in athletics is voluntary and is not a required part of the regular physical education program.

**NAME OF SPORT:** _____

SPORTS ACTIVITIES:
Identify any sports in which you do not wish your child to participate:

_____

THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER PHYSICAL WITH THE PARENT/GUARDIAN SIGNATURE. WITHOUT SUCH SIGNATURE, THE ATHLETE CANNOT RECEIVE A FINAL APPROVAL SLIP TO PARTICIPATE IN THE ATHLETIC PROGRAM.

HEALTH HISTORY

**TO BE COMPLETED BY PARENT/PERSON IN PARENTAL RELATION**

Has your child ever had: (please check all that applies)

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Seasonal allergies | ❒ | ❒ | Elevated Blood Pressure | ❒ | ❒ |
| Bee Sting Allergy | ❒ | ❒ | Headaches | ❒ | ❒ |
| Asthma | ❒ | ❒ | Head Injury/Concussion | ❒ | ❒ |
| Anemia | ❒ | ❒ | Nose Bleeds/Frequent or Severe | ❒ | ❒ |
| Arthritis | ❒ | ❒ | Ankle Injury | ❒ | ❒ |
| Bladder/Kidney Problem or Injury | ❒ | ❒ | Heart Problem/Murmur-Chest pain | ❒ | ❒ |
| Convulsions or Seizures | ❒ | ❒ | Back Pain/Injury | ❒ | ❒ |
| Fainting Spells | ❒ | ❒ | Knee Pain/Injury | ❒ | ❒ |
| Diabetes | ❒ | ❒ | Neck Injury | ❒ | ❒ |
| Ear Problems/Hearing Loss | ❒ | ❒ | Nose Fracture | ❒ | ❒ |
| Eye Problems/Vision Loss | ❒ | ❒ | Rheumatic Fever | ❒ | ❒ |
| Injury to the Spleen | ❒ | ❒ | Stomach Ulcer | ❒ | ❒ |
| Joint Sprain/Ligament Tear/ Muscle Pull | ❒ | ❒ | Fracture-Dislocation Bones/ Joints | ❒ | ❒ |

| | | |
|---|---|---|
| Is there a current medical examination on file in the nurse's office? | ❒ | ❒ |
| Is your child assigned to the Adaptive Physical Education Program? | ❒ | ❒ |
| Has your child been in the Adaptive Physical Education Program? | ❒ | ❒ |
| Does your child have one eye or severe uncorrectable loss of vision in one or both eyes? | ❒ | ❒ |
| Does your child have severe hearing loss in one or both ears? | ❒ | ❒ |
| Does your child have one (1) kidney? | ❒ | ❒ |
| Does your child have one (1) testicle? | ❒ | ❒ |
| Does your child have orthodontic appliances? | ❒ | ❒ |
| Does your child have capped teeth? | ❒ | ❒ |
| Does your child wear contact lenses for sports? | ❒ | ❒ |
| Does your child wear glasses for sports? | ❒ | ❒ |

Does your child have any food allergies? ❒**Yes** ❒**No List all:** _____
Does your child have any medication allergies? ❒**Yes** ❒**No List all:** _____

Has your child been ill for five (5) consecutive days? ❒ NO ❒ YES If so, please explain: _____

_____

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; caused your child to miss a game or practice? ❒ NO ❒ YES If yes, please explain: _____

_____

Is your child under medical care now? ❒ NO ❒ YES If yes, please explain: _____

_____

Has your child taken any medication in the past year? ❒ NO ❒ YES If so, please explain: _____

_____

Is your child taking any medications currently? ❒ NO ❒ YES If so, please explain: _____

_____

Has your child ever fainted during exercise? ❒ NO ❒ YES If so, please explain: _____

_____

Has there ever been sudden death in a family member under the age of 50? ❒ NO ❒ YES If so, please explain:

_____

_____

Do you have any concerns about your child's health or other questions you would like to discuss with a health care provider? ❒ NO ❒ YES If so, please explain: _____

_____

Since your child's last physical examination, has your child had any injury or illness? ❒ NO ❒ YES If so, please explain: _____

_____

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

I agree to a physical examination performed either by our private healthcare provider or the school physician and/or the school nurse practitioner.

I also agree to emergency medical treatment as deemed necessary by the healthcare providers designated by school authorities inclusive of over-the-counter products listed on exam page of this packet.

I have received, read, and understand the Concussion student and parent information document. I understand the signs and symptoms of a concussion and give permission for the Certified Athletic Trainer (if present) to conduct a sideline assessment to determine whether further medical care is necessary if there is suspicion that my child has withstood a head injury at an athletic event.

PARENT/PERSON IN PARENTAL RELATION'S SIGNATURE: _____

DATE: _____
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