CHILD 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:** _____

COVID-19 Information	No	Yes
1. Has your child ever tested positive for COVID-19?		
2. Was your child symptomatic?		
3. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
4. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.		
5. Was your child hospitalized? If yes, provide date(s)?		
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		
If yes, is your child under a HCP's care for this?		

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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