Physical will be conducted on: Grade _____

Date_____

Time_____

ATHLETIC HEALTH HISTORY

SCHOOL NAME:_____

STUDENT:_____DOB: _____

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

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. THE APPOINTMENT DATE FOR THE PHYSICAL EXAINATION IS IN THE UPPER LEFT HAND CORNER.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

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

	YES	NO
Is there a current medical examination on file in the nurse's office:	o	o
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	o	o
Has your child been unconscious or lost memory from a blow on the head?	o	o

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes	o	o
Severe hearing loss in both ears	o	o
One kidney	o	o
One testicle	o	o
Has your child been ill for five (5) consecutive days?	o	o

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? o o

Is your child under medical care now? o o

Has your child taken any medication in the past year? o o

If so, why?_____

Is your child taking any medications now? o o

If so, why?_____

Has your child ever fainted during exercise? o o

If so, explain._____

Has there ever been sudden death in a family member under fifty (50) years of age? o o

Do you have any worries about your child's health or other questions you would like to discuss with a doctor? o o

Does your child have: orthodontic appliances? o o

Capped teeth? o o

Wear contact lenses for sports? o o

Wear glasses for sports? o o

Since your child's last physical examination, has your child had any injury or illnesses? o o

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 designed by school authorities.

PARENT SIGNATURE:_____ **Date:**_____

(continued on next page)

FOR SCHOOL PHYSICIAN USE ONLY

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

Any unmarked categories indicates disqualification from the particular group of sports activities.

CONTACT/COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NONCONTACT	NONSTRENUOUS NONCONTACT
☐	☐	☐	☐
Field Hockey	Baseball	Crew	Archery
Football	Basketball	Cross-country	Bowling
Ice Hockey	Diving	Track and Field	Golf
Lacrosse	Gymnastics	Swimming	Riflery
Soccer	Handball	Tennis	
Wrestling	Skiing-Cross Country		
	Skiing-Downhill		
	Softball		
	Volleyball		

_____
School Physician's Signature

_____
Date