

Physical will be conducted on:
Date _____
Time _____

Grade _____

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 EXAMINATION 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	<input type="radio"/>	<input type="radio"/>	Elevated Blood Pressure	<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	<input type="radio"/>	<input type="radio"/>	Heart Problem/Murmur-Chest pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Nose Bleeds/Frequent or Severe	<input type="radio"/>	<input type="radio"/>
Bladder/Kidney Problem or Injury	<input type="radio"/>	<input type="radio"/>	Ankle Injury	<input type="radio"/>	<input type="radio"/>
Convulsions/Seizures	<input type="radio"/>	<input type="radio"/>	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"/>	Neck Injury	<input type="radio"/>	<input type="radio"/>
Eye Problems/Vision Loss	<input type="radio"/>	<input type="radio"/>	Nose Fracture	<input type="radio"/>	<input type="radio"/>
Injury to the Spleen	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<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"/>

Is there a current medical examination on file in the nurse's office: YES NO

Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?

Has your child been unconscious or lost memory from a blow on the head?

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.....	<input type="radio"/>	<input type="radio"/>
Severe hearing loss in both ears.....	<input type="radio"/>	<input type="radio"/>
One kidney.....	<input type="radio"/>	<input type="radio"/>
One testicle.....	<input type="radio"/>	<input type="radio"/>
Has your child been ill for five (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; caused your child to miss a game or practice?.....

Is your child under medical care now?.....
Has your child taken any medication in the past year?.....
If so, why?.....

Is your child taking any medications now?.....
If so, why?.....

Has your child ever fainted during exercise?.....
If so, explain.....

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

Do you have any worries about your child's health or other questions you would like to discuss with a doctor?.....
Does your child have: orthodontic appliances?.....
Capped teeth?.....
Wear contact lenses for sports?.....
Wear glasses for sports?.....
Since your child's last physical examination, has your child had any injury or illnesses?..

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Diving Gymnastics Handball Skiing-Cross Country Skiing-Downhill Softball Volleyball	Crew Cross-country Track and Field Swimming Tennis	Archery Bowling Golf Riflery

School Physician's Signature

Date