

STUDENT HEALTH HISTORY

NAME: _____ DOB: _____ AGE: _____ SEX: _____

Parent's or guardian's Permission: I certify that this information is true and I consider him/her physically capable of participating in school activities and/or athletics. I understand that this history is not a complete one, but a screening for participation in an athletic program. I will bring to the attention of the school staff during the year, any medical problems that might affect his/her health. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become necessary for the student in the course of such activities. I also agree not to hold the school or anyone acting in its behalf, responsible for any injury or emergency treatment of such injuries occurring to the above named student.

List Allergies (including reactions to medications): _____

List Medication being taken on a regular basis: _____

YES	NO	
		Any Asthma, if yes do they use an inhaler:
		Any diabetes, if yes talk to coach and explain emergency procedure
		Any other chronic illness, if yes explain:
		Any illnesses lasting more than one week
		Any bleeding tendencies
		Any yellow jaundice
		Any hospitalizations
		Any surgery other than tonsillectomy
		Any injuries requiring treatment by a physician
		Presently taking any medications, if yes explain:
		Any problem with blood pressure or heat
		Any dizziness, fainting, convulsions, or frequent headaches
		Ever been knocked out
		Wear glasses or contact lenses
		Wear any dental appliances
		Allergic to any medications, if yes explain:
		Any knee injury
		Any ankle injury
		Any neck injury
		Any sprains or dislocations
		Any broken bones
		Any organ missing (Appendix, Eye, Kidney, etc.), if yes explain:
		Any heat exhaustion or stroke
		History of family member under 50 (heart attack or heart problems)
		Have there been any health problems in the last year
		Any loss of consciousness or severe headaches
		Any joint injury
		Do you know any reason why this applicant should NOT participate in sports
		List any other health problem(s) we should know about this student

Are there any physical or medical conditions we should know about not already stated? _____

May we administer the following medications to your child? Tylenol ___ yes ___ no Cough Drops ___ yes ___ no
 Tums ___ yes ___ no Neosporin ___ yes ___ no

PARENT SIGNATURE _____ DATE _____

PLEASE BE SURE TO FILL OUT BOTH SIDES OF THIS DOCUMENT