Red Creek Central School

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	❑	❑	Elevated Blood Pressure	❑	❑
Bee Sting Allergy	❑	❑	Headaches	❑	❑
Asthma	❑	❑	Head Injury/Concussion	❑	❑
Anemia	❑	❑	Heart Problem/Murmur-Chest pain	❑	❑
Arthritis	❑	❑	Nose Bleeds/Frequent or Severe	❑	❑
Bladder/Kidney Problem or Injury	❑	❑	Ankle Injury	❑	❑
Convulsions/Seizures	❑	❑	Back Pain/Injury	❑	❑
Fainting Spells	❑	❑	Fracture-Dislocation Bones/Joints	❑	❑
Diabetes	❑	❑	Knee Pain/Injury	❑	❑
Ear Problems/Hearing Loss	❑	❑	Neck Injury	❑	❑
Eye Problems/Vision Loss	❑	❑	Nose Fracture	❑	❑
Injury to the Spleen	❑	❑	Rheumatic Fever	❑	❑
Joint Sprain/Ligament Tear/Muscle Pull	❑	❑	Stomach Ulcer	❑	❑

	YES	NO
Is there a current medical examination on file in the nurse's office:	❑	❑
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……	❑	❑
Severe hearing loss in both ears……	❑	❑
One kidney……	❑	❑
One testicle……	❑	❑
Has your child been ill for five (5) consecutive days?……	❑	❑

_____

_____

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
☐	☐	☐	☐
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