

Islander Middle School ATHLETIC HEALTH FORM

To be filled out by the student/parent

Student _____ Birth Date _____ Grade _____ Gender _____

Address _____ Hm. Phone _____ Wk. Phone _____

Physician's Name (Please Print) _____ Phone _____

Physician's Address _____

Date of last Tetanus Immunization? _____ Date of last Measles Immunization? _____

Explain "Yes" answers below No Yes

1. Overnight hospitalizations, operations or surgery? Dates ☐ ☐

2. Are you presently taking any medication or pills? ☐ ☐

3. Do you have any allergies/conditions that are life threatening* or affect school/sports? ☐ ☐

4. Have you ever passed out during or after exercise? ☐ ☐

Have you ever been dizzy during or after exercise? ☐ ☐

Do you tire more quickly than your friends during exercise? ☐ ☐

Have you ever had high blood pressure? ☐ ☐

Have you ever been told that you have a heart murmur? ☐ ☐

Have you ever had racing of your heart or skipped heartbeats? ☐ ☐

Anyone under 50 yrs old in the family die of heart problems? ☐ ☐

5. Do you have any skin problems? ☐ ☐

6. Have you ever had a head injury? ☐ ☐

Have you ever been knocked out or unconscious? ☐ ☐

Have you ever had a seizure? ☐ ☐

Have you ever had a stinger, burner or pinched nerve? ☐ ☐

7. Have you ever had heat or muscle cramps? ☐ ☐

Have you ever been dizzy or passed out in the heat? ☐ ☐

8. Do you have trouble breathing or do you cough during or after activity? ☐ ☐

9. Do you use any special equipment (pads, braces, mouth guard, etc)? ☐ ☐

10. Have you had any problems with your eyes or vision? ☐ ☐

Do you wear glasses or contacts or protective eye or vision? ☐ ☐

11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ ☐

☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Foot

☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand

Explain "Yes" answers to Questions 1-11 above: _____

*WAC 180-38-045 Attendance of every student at every public school who has a life threatening health condition is conditioned upon: Parent presentation of a medication/treatment order and formulation of a nursing plan to implement the order.

The signature below indicates that a parent/guardian and the participating student acknowledge they have carefully read this form and the above information is true.

STUDENT SIGNATURE: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____