

Remsen Central School

ATHLETIC HEALTH HISTORY

THIS FORM MUST BE COMPLETED AND RETURNED ASAP

NAME _____ BIRTHDATE _____
 GRADE _____

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 in

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		
Arthritis			Nose Bleeds/Frequent or Severe		
Bladder/Kidney Problem or Injury			Ankle Injury		
Convulsions/Seizures			Back Pain/Injury		
Fainting Spells			Fractures/Dislocation Bones/Joints		
Diabetes			Knee Pain/Injury		
Ear Problems/Hearing Loss			Neck Injury		
Eye Problems/Vision Problems			Nose Fractures		
Injury to the Spleen			Rheumatic Fever		
Joint Sprain/Ligament Tear/Muscle Pull			Stomach Ulcers		

Is there a current medical examination on file in the nurses office? ___ Yes ___ No

Is your child assigned to the Adaptive Physical Education Program or has he/she been in an Adaptive Physical Education? ___ Yes ___ No

Has your child been unconscious or lost memory form a blow on the head ___ Yes ___ No

Does your child have the following:

Severe uncorrectable loss of vision in one eye? Yes No or

Both eyes? Yes No

Has your child been ill for five(5) consecutive days? Yes No

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 a operation: caused your child to miss a game or practice? Yes No

Please explain

_____ Is your child under medical care now? Yes No

Has your child taken any medication in the past year? Yes No If so, why

Is your child under medical care now? Yes No

Has your child taken any medication now? Yes No If so why? _____

Has your child ever fainted during exercise? Yes No If so, why? _____

Has there ever been a sudden death of a family member under Fifty(50) years of age? Yes No

Do you have any worries about your child's health or other questions that you would like to discuss with a doctor? Yes No If so, explain: _____

Does you child have:

Orthodontic Appliances Yes No _____

Capped Teeth Yes No _____

Wear contact lens for sports Yes No _____

Wear glasses for sports Yes No _____

Shatter proof lens/sports glasses Yes No _____

Since your child's last physical examination, has your child had any injury or medical illness? Yes

No If so, explain:

I agree with the above answers and consent to the participation of my child in the interscholastic program of his or her school, including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

PARENT SIGNATURE _____ DATE _____