GLOVERSVILLE ENLARGED SCHOOL DISTRICT

ATHLETIC HEALTH HISTORY

Grade_____

Sport ___________________

Name____BirthDate__________________

Participation in athletics is voluntary and is not a required part of the regular physical education program.

THIS FORM MUST BE COMPLETED AND RETURNED PRIOR TO THE DAY THE ATHLETE HAS HIS/HER PHYSICAL.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	No	Yes	Explain if yes
Allergies/Hay Fever	______	______	______________________
Bee Sting Allergy	______	______	______________________
Asthma	______	______	______________________
Anemia	______	______	______________________
Arthritis	______	______	______________________
Bladder/Kidney/Problem Or Injury	______	______	______________________
Convulsions/Seizures	______	______	______________________
Fainting Spells	______	______	______________________
Diabetes	______	______	______________________
Ear Problems/ Hearing Loss	______	______	______________________
Eye Problems/ Vision Loss	______	______	______________________
Injury to the Spleen	______	______	______________________
Joint Sprain/Ligament	______	______	______________________
Tear/Muscle Pull			
Elevated Blood Pressure	______	______	______________________
Headaches	______	______	______________________
Head Injury/Concussion/ Unconscious	______	______	______________________
Heart Problem/Murmur/ Chest Pains	______	______	______________________
Nose Bleeds/Frequent/ Severe	______	______	______________________
Ankle Injury	______	______	______________________
Back Pain/Injury	______	______	______________________
Fracture-Dislocation Bones/Joints	______	______	______________________
Knee Pain/Injury	______	______	______________________
Neck Injury	______	______	______________________
Nose Fracture	______	______	______________________
Rheumatic Fever	______	______	______________________
Stomach Ulcer	______	______	______________________

(OVER)

History Continued

Does your child have any of the following:

If you answer yes to any questions please explain

	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? (In past 1 year) ________________________	☐	☐

____

____

	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 an operation; caused your child to miss a game or practice?(In past 1 year) ____	☐	☐

____

____

	Yes	No
Is your child under medical care now? ____	☐	☐
Has your child taken any medication in the past year?____________________________________	☐	☐

If so, why?____

____

____

	Yes	No
Is your child taking any medication now?____	☐	☐

If so, why?____

____

	Yes	No
Has your child ever fainted or been dizzy during or after exercise?______________________________	☐	☐
If so, explain____		
Has there ever been sudden death in a family member under fifty (50) years of age?________________	☐	☐

____

	Yes	No
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 lens for sports?____	☐	☐
Wear glasses for sports?____	☐	☐
Since your child's last physical examination has your child had any injury or medical illness?________	☐	☐

____

	Yes	No
Is your child able to run a half mile (2 times around the track) without stopping?____________________	☐	☐

If not, please explain____

____

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 athletic contests.

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

PARENT SIGNATURE___________________________________ DATE________________________