ATHLETIC HEALTH HISTORY

(This form must be filled out and handed to coaches
within 30 days <u>prior</u> to the start of every season)

Athlete's name _____

Sport _____ Grade _____

FALL WINTER SPRING

DO YOU HAVE : (please indicate yes or no)

1. Severe insect sting or allergy? _____
   Medication in school for allergy? _____

2. History of concussion, loss of consciousness
   or memory loss from a head injury? _____

3. Asthma? _____
   Medication in school for asthma? _____

4. Heart problem or murmur? _____
   Evaluated by a cardiologist? _____

5. Seizure disorder _____
   Medication in school for seizure? _____

6. Any other chronic disease or condition? _____

7. Only one kidney or testicle? _____

8. Uncorrectable severe vision loss in one _____
   eye or both eyes?

9. Hearing loss in one ear or both ears? _____

10. Sudden death (not accidental) in a
    family member under 50? _____

11. Had any injuries requiring medical attention within _____
    the past year?
    Any current restrictions due to injuries? _____

12. Had any surgical procedures within the last year? _____

13. Currently under a physician's care or taking any _____
    medications?
14. Wear contact lenses or glasses_____ dental appliances_____

Please explain any yes answers

_____

_____

_____

_____

_____

_____ _____
Signature of <u>Parent</u> Date