To be filled out at first practice and returned to Ms. Davey

Student name:

Have you ever had or do you currently have:	Responses	Details (specific information, dates, explanations)
Allergies (pollen, bees, latex, shellfish, ice, medications)	❒ Yes ❒ No	If yes, do you carry an Epipen? _____ Allergic to:
Anemia/Blood Conditions	❒ Yes ❒ No	
Asthma/Breathing Difficulties	❒ Yes ❒ No	If yes, do you carry an inhaler? _____
Concussion/Head Injuries	❒ Yes ❒ No	# Diagnosed: _____
Contact Lenses/Glasses	❒ Yes ❒ No	
Dental Appliances	❒ Yes ❒ No	
Diabetes/Blood Sugar Conditions	❒ Yes ❒ No	
Eating Disorders	❒ Yes ❒ No	
Epilepsy/Seizures	❒ Yes ❒ No	
Heart Conditions (Palpitations, Murmurs, etc.)	❒ Yes ❒ No	
Mental Health Concerns (Depression, Anxiety, etc.)	❒ Yes ❒ No	
Recent Surgeries	❒ Yes ❒ No	
Use of Special Braces or Equipment	❒ Yes ❒ No	
Use of Daily Medications	❒ Yes ❒ No	If yes, please list medication and use: