NORTH WARREN CENTRAL SCHOOL ATHLETIC HEALTH HISTORY

STUDENT:_____DOB: _____

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

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

Has your child been unconscious or lost memory from a blow on the head? ☐ ☐

Does your child have any of the following:

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 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?_____ ☐ ☐

_____

Is your child under medical care now?……. ☐ ☐

Has your child taken any medication in the past year?……. ☐ ☐

If so, why?_____

_____

_____

Is your child taking any medications now?…….. ☐ ☐

If so, why?_____

Has your child ever fainted during exercise?…… ☐ ☐

If so, explain._____

Has there ever been sudden death in a family member under fifty (50) years of age?……. ☐ ☐

_____

Do you have any worries about your child's health you would like to discuss with the Dr.

……. ☐ ☐

Does your child have: orthodontic appliances?…… ○ ○

Capped teeth?……. ○ ○

Wear glasses or contact lenses for sports?……. ○ ○

Since your child's last physical examination, has your child had any injury or illnesses?.. ○ ○

_____

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

PARENT SIGNATURE:_____**Date**:_____