

TO BE COMPLETED BY PARENT

STUDENT ATHLETE HEALTH HISTORY FORM

Date _____ Name _____

Sport _____ Birth date _____

PLEASE ANSWER ALL QUESTIONS.

1. Has had...
 - a. Rheumatic fever or Scarlet fever yes ___ no ___
 - b. Seizure or consecutive disorder yes ___ no ___
 - c. Anemia (including sickle cell anemia) yes ___ no ___
 - d. Mononucleosis or hepatitis yes ___ no ___
 - e. Asthma yes ___ no ___
 - f. Diabetes yes ___ no ___
 - g. High blood pressure yes ___ no ___
 - h. Kidney disease yes ___ no ___
 - i. Retinal detachment or eye disorder yes ___ no ___
 - j. Absence of a paired organ (such as a kidney) yes ___ no ___
 - k. Concussion (if yes, how many times? ____) yes ___ no ___
 - l. Thyroid disease yes ___ no ___
 - m. Gastrointestinal disease yes ___ no ___
2. Any known allergies? yes ___ no ___
 - Name drugs:
 - Other:
3. Take any medication now? yes ___ no ___
 - Name of medication:
4. Under a physician's care now? yes ___ no ___
 - Name:
5. Had an illness lasting more than a week yes ___ no ___
6. Have been in the hospital (except tonsillectomy) yes ___ no ___
7. Has had surgery? yes ___ no ___
8. Has had tetanus immunization? (date) yes ___ no ___
9. Wears glasses or contact lenses? yes ___ no ___
10. Last menstrual period (date) yes ___ no ___
11. Has had emotional problems requiring medical care? yes ___ no ___
12. Has had low back pain? yes ___ no ___
13. Has had an injury of a muscle, bone, joint, ligament, or tendon? yes ___ no ___
14. Have you received any serious injury or illness since participating in this sport last year? yes ___ no ___
15. Pass out – faint? yes ___ no ___

PLEASE EXPLAIN ANY "YES" ANSWERS TO ABOVE QUESTIONS.

TO BE COMPLETED BY PHYSICIAN

STUDENT ATHLETE PHYSICAL EXAM FORM

Name _____ Birth date _____

Ht. _____ Wt. _____ BP _____ Resp. _____ Pulse _____

Eyes: R20/ _____ Glasses _____
L20/ _____ Contacts _____

Dental Evaluation _____

Ears _____ Nose _____ Throat _____

Adenopathy _____

Lungs _____

Cardiovascular _____

Abdominal _____

Hernia _____

Musculoskeletal _____

Neck _____

Shoulder _____

Upper Extremities _____

Thoracic Lumbo – Sacral Spine _____

Pelvis and Hips _____

Lower Extremities _____

Knees _____

Ankles _____

Feet _____

Neurological _____

Lab _____ Urine _____ HGB/HCT _____ Sickeldex _____

Comments: _____

- ___ 1. No athletic participation
- ___ 2. Limited participation (specific sports must be listed) _____
- ___ 3. Clearance withheld until additional tests, exam, or rehabilitation is complete.
- ___ 4. Full, unlimited participation

Date _____ Signature _____