HOOSIC VALLEY CENTRAL SCHOOL DISTRICT
JR/SR HIGH SCHOOL HEALTH OFFICE-PHONE:753-4458 EXT 2511/FAX: 753-4151

ATHLETIC HEALTH HISTORY

Complete this form if this is the student's FIRST TIME participating in interscholastic sports.

STUDENT:_____DOB: _____GRADE:_____

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

SPORTS ACTIVITIES

Identify any sports in which you *do not* wish your child to participate:
_____

THIS FORM MUST BE COMPLETED AND RETURNED WITH COMPREHENSIVE PHYSICAL EXAMINATION PRIOR TO THE START OF TRYOUTS (unless physical exam is already on file.)

Please note: This form cannot be filled out more than 30 days prior to the start of the sport. Do not send into nurse before then. Thank you.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	o	o	Elevated Blood Pressure	o	o
Bee Sting Allergy	o	o	Headaches	o	o
Asthma	o	o	Head Injury/Concussion	o	o
Anemia	o	o	Heart Problem/Murmur-Chest pain	o	o
Arthritis	o	o	Nose Bleeds/Frequent or Severe	o	o
Bladder/Kidney Problem or Injury	o	o	Ankle Injury	o	o
Convulsions/Seizures	o	o	Back Pain/Injury	o	o
Fainting Spells	o	o	Fracture-Dislocation Bones/Joints	o	o
Diabetes	o	o	Knee Pain/Injury	o	o
Ear Problems/Hearing Loss	o	o	Neck Injury	o	o
Eye Problems/Vision Loss	o	o	Nose Fracture	o	o
Injury to the Spleen	o	o	Rheumatic Fever	o	o
Joint Sprain/Ligament Tear/Muscle Pullo		o	Stomach Ulcer	o	o

	YES	NO
Is there a current medical examination on file in the nurse's office?	o	o

Date of physical_____

Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	o	o
Has your child been unconscious or lost memory from a blow on the head?	o	o

(over →)

History Continued

Does your child have any of the following?

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes……	o	o
Severe hearing loss in both ears……	o	o
One kidney…….	o	o
One testicle……	o	o
Has your child been ill for five (5) consecutive days?…….	o	o

_____

_____

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?_____ o o

_____

Is your child under medical care now?…….	o	o
Has your child taken any medication in the past year?…….	o	o

If so, why?_____

_____

_____

_____

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

If so, why?_____

_____

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

If so, explain._____

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

_____

Do you have any worries about your child's health or other questions you would like to discuss with a doctor?……	o	o
Does your child have: orthodontic appliances?……	o	o
Capped teeth?…….	o	o
Wear contact lenses for sports?…….	o	o
Wear glasses for sports?……	o	o
Since your child's last physical examination, has your child had any injury or illnesses?..	o	o

_____

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 designated by school authorities.

PARENT SIGNATURE:_____**Date**:_____

_____

HEALTH OFFICE USE ONLY

Date reviewed:_____ **Nurse's signature:**_____

☐ **Approved** ☐ **Referred to School Physician**