

Health History / Physical Evaluation

The Health History is to be completed for all students by the parent.

Name _____	Sex _____	Age _____
Date of Birth _____	Phone _____	Grade _____ School _____

Explain "Yes" answers at the bottom of this form.

	YES	NO
1. Has your child had a medical illness or injury since their last check up or physical?		
Does your child have an ongoing or chronic illness? (for example, Diabetes, Kidney Disease)		
Does your child have a bleeding tendency? (For example, severe or frequent nosebleeds, dysmenorrhea?)		
Has your child ever had or have jaundice?		
Has your child ever had tuberculosis or a positive skin test for any reason?		
2. Is your child missing one of a paired organ or the function of one of a paired organ? (ie: Eye, Kidney, Lung, Testicle)		
3. Has your child ever been hospitalized overnight?		
Has your child ever had surgery?		
4. Is your child currently taking any prescription or non-prescription (over-the-counter) medications or using an inhaler?		
Has your child ever taken any supplements or vitamins to help them gain or lose weight or improve their performance?		
5. Does your child have any allergies (for example, to pollen, medicine, food, latex or stinging insects)? <i>Please explain all allergies, including medication information, in detail, below.</i>		
6. Has your child ever passed out or been dizzy during or after exercise?		
Has your child ever had chest pains during or after exercise?		
Does your child get tired more quickly than their friends do during exercise?		
Has your child ever had their heart race or skip heartbeats?		
Has your child had high blood pressure or high cholesterol?		
Has your child ever been told they have a heart murmur?		
Has your child had a family member or relative died of heart problems or of sudden death before age 50?		
Has your child had a severe viral infection (for ex: myocarditis or mononucleosis) within the last month?		
Has your child's physician ever denied or restricted their participation in any activity or sports for any heart problems?		
7. Does your child have any current skin problems - for example, itching, rashes, acne, warts, fungus or blisters?		
8. Has your child ever had a head injury or concussion?		
Has your child ever been knocked out, become unconscious, or lost their memory?		
Has your child ever had a seizure?		
Does your child have frequent or severe headaches?		
Has your child ever had numbness or tingling in their arms, hands, legs, or feet?		
Has your child ever had a stinger, burner, or pinched nerve?		
9. Has your child ever become ill from exercising in the heat?		
10. Does your child cough, wheeze, or have trouble breathing during or after activity?		
Does your child have asthma?		
Does your child have seasonal allergies that require medical treatment?		
11. Does your child have to use any special protective or corrective equipment or devices that are not usually used for regular physical activity, sports or position (for example, knee brace, special neck roll, foot orthotics, retainer on their teeth, hearing aid)?		
12. Has your child had any problems with their eyes or vision?		
Does your child wear glasses, contact lenses or protective eyewear?		
13. Does your child have any difficulty hearing?		
14. Has your child ever had a sprain, strain or swelling after injury?		
Has your child ever broken or fractured any bones or dislocated any joints?		
Has your child had any other problems with pain or swelling in muscles, bones, or joints?		

If **yes**, check appropriate box and explain below:

	Ankle		Chest		Foot		Knee		Shoulder
	Arm		Elbow		Hand		Neck		Thigh
	Back		Finger		Head		Shin / Calf		Wrist

Please explain those injuries:

15. Does your child want to weigh more or less than they do now?		
Does your child lose weight regularly to meet weight requirements for their sport?		
16. Does your child feel stressed out?		

Explain "YES" answers to all questions here:

QUESTION # 17 IS FOR FEMALE JUNIOR AND SENIOR HIGH SCHOOL STUDENT ONLY

When was your most recent period? (date)		
How many days do you usually have from the start of one period to the start of another?		
How many periods have you had in the last year?		
What was the longest time between your periods in the last year?		

A current tetanus shot (one received within the last ten years) is required for participation in all Interscholastic Sports.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student _____ Date _____

Signature of parent/guardian _____ Date _____