

STUDENT NAME: _____
 (Last) (First) (M.I.)

GENDER: () Male () Female BIRTHDATE: _____

HEALTH HISTORY – TO BE COMPLETED BY PARENT/GUARDIAN

This section is to be carefully completed by the student and his/her parent(s) or legal guardians(s) before participation in activities/interscholastic sports in order to help detect possible risks.

MARK ONLY THOSE WHICH APPLY! Include date for conditions that are not current. Explain “Yes” answers below.

Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	False Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glasses/Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy/Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough (Pertussis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain “Yes” here: _____

List all surgeries, fractures, sprains, or dislocations below:

Nature of problem	Year	Nature of problem	Year

Reasons and dates for any prolonged absence(s) from school: _____

Substance(s) to which student is allergic: _____

Dates of most recent: Tetanus Booster _____ Chest x-ray _____ Smallpox vaccination _____

Whooping Cough (Pertussis) vaccination _____

PHYSICAL EXAMINATION SUMMARY – TO BE COMPLETED BY PHYSICIAN

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Note any abnormalities:

Eyes (sclera, corneas): _____

Ears (canals, TMs): _____

Nose (septum, mucosa): _____

Throat (tonsils, teeth): _____

Cardiovascular (pulses, murmurs): _____

Respiratory: _____

Abdomen (organs, masses): _____

Genitalia (testes, hernia): _____

Musculoskeletal: _____

Neurological: _____

Strength and Coordination: _____