# Health History Questionnaire

This form is be completed by parent, guardian or physician prior to each sport season for the purpose of granting permission for interscholastic sports to be played by my son/daughter:

Student-Athlete: ______________________________ Sport: ______________________

Please mark the appropriate column for everything that applies to the previous 12 months. If your answer is "yes" to any of the following questions please explain at the bottom of the page in the space provided.

| Yes | No | |
|---|---|---|
| □ | □ | Any known medical condition |
| □ | □ | Any known allergies |
| □ | □ | Take daily or frequent medication |
| □ | □ | Emergency room visit/ or hospitalization |
| □ | □ | Operation |
| □ | □ | Any known heart disease or murmur |
| □ | □ | High Blood Pressure |
| □ | □ | Asthma or difficulty breathing |
| □ | □ | Bleeding tendency or blood disease |
| □ | □ | Head Injury |
| □ | □ | Any feeling of faintness, dizziness, excessive fatigue, loss of consciousness |
| □ | □ | Any history of seizures |
| □ | □ | Any history of headaches or migraines |
| □ | □ | Poor vision, eye glasses, contacts |
| □ | □ | Orthodontic braces |
| □ | □ | Hearing impairment |
| □ | □ | History of diabetes |
| □ | □ | History of urinary problems, loss of kidney, loss of testicle |
| □ | □ | Loss of any other organ |
| □ | □ | History of broken bones or joint disease |

Please explain all "yes" answers:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

By signing, I indicate my understanding that the questions are asked in order to help evaluate the readiness of the student athlete to participate in the interscholastic athletics. Any "yes" answers do not mean the student is unable to play in the athletic activity indicated.

In case of an accident or serious illness I request that the school nurse, coach, administrator, or his /her designee seek medical care for my child and make any necessary medical decisions until I can be reached. I understand and accept that the information provided may be shared on an "as needed "basis in order to ensure the safety and well being of my child. I hereby certify that the above information is correct.

Parent/Guardian (print) ____________________________________________

Signature__________________________________________________Date________

Medical Clearance Stamp

Medical Alert