

Canajoharie Central School Athletic Health History

Last Name _____ First Name _____

Date of Birth _____

Please indicate if your child will have a school sport physical or a sport physical with a private physician (school form must be used) _____

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

This form must be completed and returned to the school nurse prior to the school sport physical or turned in with a privately completed physical form.

Health History to be **completed by parent/guardian**

Has your child ever had (please check)

	Yes	No		Yes	No
Allergies	—	—	Elevated Blood Pressure	—	—
Bee Sting Allergy	—	—	Headaches	—	—
Asthma	—	—	Head Injury/Concussion	—	—
Anemia	—	—	Heart Problem/Murmur Nose	—	—
Arthritis	—	—	Bleeds (frequent/severe)	—	—
Bladder/Kidney problem or injury	—	—	Ankle Injury	—	—
Convulsions/Seizures	—	—	Back Pain/Injury	—	—
Fainting Spells	—	—	Fracture or Dislocation	—	—
Diabetes	—	—	Knee Pain/Injury	—	—
Ear Problems/Hearing Loss	—	—	Neck Injury	—	—
Eye Problems/Vision Loss	—	—	Nose Fracture	—	—
Injury to the Spleen	—	—	Rheumatic Fever	—	—
Joint Sprain/Ligament Tear	—	—	Stomach Ulcer	—	—

Please explain yes answers below:

Is your child assigned to the Adaptive Physical Education Program? Yes No
— —

Has your child been unconscious or lost memory from a blow to the head? — —

Does your child have any of the following? Yes No

Only one kidney — —

Only one testicle — —

	Yes	No
One eye or severe uncorrectable loss of vision in one or both eyes	___	___
Severe Hearing Loss in both ears	___	___
Has your child been ill for 5 consecutive days? Explain	___	___

Has your child ever had an illness, condition or injury that required him/her to stay overnight at the hospital? Please explain. ___ ___

Has your child taken medication in the past year? ___ ___

If so, why _____

Is your child taking any medication now? ___ ___

If so, why? _____

Has your child ever fainted during exercise? ___ ___

If so, explain _____

Has there ever been sudden death due to a cardiac cause in a family member under fifty years? ___

Does your child have orthodontic appliances? ___ ___

Capped teeth/bridge/false teeth? ___ ___

Wear contact lenses for sports? ___ ___

Wear glasses for sports? ___ ___

Since the last physical has your child had any serious injury or medical illness? ___ ___

If so, explain _____

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 athletic contests. I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent Signature _____ Date _____