



MEDICAL HISTORY FORM

NAME		SPORT		GRADE	
DOB		HOME#		HEIGHT	
PARENT/GUARDIAN		CELL#		WORK#	
DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?					
YES	NO		YES	NO	
		HEART CONDITION			ARTHRITIS
		LUNG/BREATHING CONDITION			PREVIOUS SURGERY
		ALLERGIC REACTION TO MEDS			ALLERGIES
		EPILEPSY/SEIZURES			DIABETES
		HIGH BLOOD PRESSURE			BLEEDING (HEMOPHILIA)
		HERNIA/RUPTURE			OTHER

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

HAVE YOU EVER INJURED ANY OF THE FOLLOWING, INCLUDING FRACTURES, DISLOCATION, SPRAINS, STRAINS, CONCUSSIONS, BRUISES? PLEASE INDICATE IF SURGERY WAS NECESSARY.

HEAD/NECK:

NOSE, FACE, TOOTH OR JAW

SHOULDER, ARM OR HAND

BACK, RIBS OR ABDOMEN

HIP, LEG, KNEE, ANKLE OR FOOT

DO YOU WEAR GLASSES/CONTACT LENSES? _____ YES _____ NO _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____ YES _____ NO _____ IF YES, PLEASE LIST:

STUDENT ATHLETE SIGNATURE
SIGNATURE

*PARENT/GUARDIAN

* SIGNATURE INDICATES STUDENT HAS BEEN SEEN BY PHYSICIAN WITHIN 2 YEARS AND IS CLEARED FOR ACTIVITY