Spencer Van Etten School District

Athletic Health History

STUDENT: _____ DOB_____ Grade _____

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

Sports Activities:

Identify any sports in which you **do not wish** your child to participate:

_____

THIS FORM MUST BE COMPLETED AND RETURNED ONE WEEK BEFORE THE ATHLETE HAS HIS/HER PHYSICAL.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	o	o	Elevated Blood Pressure	o	o
Bee Sting Allergy	o	o	Injury to Spleen	o	o
Asthma	o	o	Head Injury/Concussion	o	o
Anemia	o	o	Heart Problem/Murmur-Chest pain	o	o
Arthritis	o	o	Nose Bleeds/Frequent or Severe	o	o
Bladder/Kidney Problem or Injury	o	o	Ankle Injury	o	o
Convulsions/Seizures	o	o	Back Pain/Injury	o	o
Fainting Spells	o	o	Fracture-Dislocation Bones/Joints	o	o
Diabetes	o	o	Knee Pain/Injury	o	o
Ear Problems/Hearing Loss	o	o	Neck Injury	o	o
Eye Problems/Vision Loss	o	o	Nose Fracture	o	o
Headaches	o	o	Rheumatic Fever	o	o
Joint Sprain/Ligament Tear/Muscle Pullo		o	Stomach Ulcer	o	o

	YES	NO
Is there a current medical examination (within 1 yr) on file in the nurse's office:	o	o
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education? (a special PE class)	o	o
Has your child been unconscious or lost memory from a blow on the head?	o	o

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes.....	o	o
Severe hearing loss in both ears.....	o	o
One kidney.....	o	o
One testicle (males).....	o	o
Has your child been ill for five (5) consecutive days? If yes, time period.....	o	o
_____		
Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? If yes, time period_____	o	o
_____		
Is your child under medical care now?.....	o	o
Has your child taken any medication in the past year?.....	o	o
If so, why?_____		

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	YES	NO
Is your child taking any medications now?	o	o
If so, why? _____		
Has your child ever fainted during exercise?	o	o
If so, explain. _____		
Has there ever been sudden death in a family member under fifty (50) years of age?	o	o
_____		
Does your child have: orthodontic appliances?	o	o
Capped teeth?	o	o
Wear contact lenses for sports?	o	o
Wear glasses for sports?	o	o
Since your child's last physical examination, has your child had any injury or illnesses?	o	o
If yes, 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 the athletic contests.

PARENT SIGNATURE:_____ **Date:**_____

* *

FOR SCHOOL PHYSICIAN USE ONLY

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

Any unmarked categories indicates disqualification from the particular group of sports activities.

CONTACT/COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NONCONTACT	NONSTRENUOUS NONCONTACT
☐	☐	☐	☐
Field Hockey Football Wrestling Soccer	Baseball Basketball Softball Volleyball	Track and Field Cross-country	Golf

_____
School Physician's Signature

_____
Date