SPORTS HEALTH HISTORY QUESTIONNAIRE

NAME_________________________________ **Date of Birth**____________ **Grade**___________

Sex M/F **Sport**___________________ **School**__________________________

THIS FORM MUST BE COMPLETED BY PARENT/GUARDIAN

	YES	NO
Does your child have any allergies	◻	◻
Has your child ever had a rash or hives during or after exercise	◻	◻
Has your child ever been dizzy or passed out during or after exercise	◻	◻
Does your child have any skin problems-sores-open areas	◻	◻
Has your child ever had a concussion or lost consciousness	◻	◻

	YES	NO
Does your child currently take any medications on a regular or as needed basis	◻	◻
Has your child ever been diagnosed with a blood or bleeding disorder	◻	◻
Males Only: Do you have only one kidney/testicle	◻	◻

Females Only:
When was most recent menstrual period month/year ____/______

Has your child ever had: (please check)

Bee sting allergy or needed Epipen	◻	◻
Asthma	◻	◻
Arthritis	◻	◻
Bladder/Kidney problems	◻	◻
Seizures/Epilepsy	◻	◻
Diabetes	◻	◻
Elevated Blood Pressure	◻	◻
Frequent Headaches	◻	◻
Heart Murmur/Chest pain	◻	◻
Nose Bleeds/Frequent or Severe	◻	◻
Neck or Back Injury/Pain	◻	◻
Fracture-Dislocation Bones/Joints	◻	◻
Rheumatic Fever	◻	◻
Knee or Ankle Injury/Pain	◻	◻

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN THE ILLNESS OR INJURY AND GIVE APPROXIMATE DATES:

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Does your child have any of the following:

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 five consecutive days…………………………………………………..	◻	◻
Is your child under medical care now………………………………………………………………..	◻	◻
Does your child have orthodontic appliances or capped teeth…………………………………..	◻	◻
Has your child ever had surgery-if yes please list type and year below………………………..	◻	◻
Since your child's last physical, has your child had any injury or illnesses………………………	◻	◻
Has there ever been sudden death in a family member under fifty years of age…………………	◻	◻

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I agree with the above answers and consent to participation of my child in the interscholastic program of Malone Central School District including practice sessions and travel to and from athletic contests.
I give consent for pertinent medical information to be shared with the appropriate staff.

PARENT SIGNATURE:_____________________________________ **DATE:**_______________________

HOME PHONE:__________________ **CELL PHONE:**_____________________