HEALTH HISTORY

This form must be completed, signed by parent or guardian, and returned to the school nurse prior to a school physical and prior to **each** sports season.

Name _____ Date of Birth ___/__/_____
Grade _____ Age _____ Weight _____ Date of last Tetanus Shot ___/__/_____
Sport: _____ Circle level: Modified JV Varsity
Medication allergies _____ Medications taken: _____
Allergy to bee stings? ( ) yes ( ) no *Epi-Pen? ( ) yes ( ) no

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Is there a history of: (Indicate **YES** or **NO** and write comments or explanations in the section indicated below for **ALL YES** answers. Use back if needed.)

		Hayfever/seasonal allergies	___
Congenital heart disease	___	Dislocation of knee cartilage	___
Acquired heart disease	___	Dislocation of other joints	___
Hernia	___	Fractures	___
Cough with exercise	___	Fainting episodes	___
Chronic illnesses	___	Head injury/Concussion	___
Sudden death of close relative	___	Any prior athletic disqualification	___
Lung disease/Asthma	___	Surgical operations	___
*If yes, Inhaler?	___	Glasses/contacts (circle)	___

*__Reminder:__ Medication Administration Form and Self-Medication Form must be completed and on file in health office before your child will be allowed to carry and self-administer their inhaler or Epi-Pen.

Comments:_____
_____
_____
___

Date _____Parent/Guardian Signature
_____

PARENTAL PERMISSION (for sports participation):

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named above. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: _____/_____/_____