ATHLETE MEDICAL HISTORY FORM

ATHLETES NAME_____ DOB_____

ADDRESS_____ MALE____ FEMALE____

_____ PHONE_____

SCHOOL_____ GRADE _____ SPORT_____

EMERGENCY CONTACT_____ PHONE_____

FAMILY PHYSICIAN_____ PHONE_____

HAVE YOU EVER HAD OR DO YOU HAVE:

	YES	NO		YES	NO
HEAD INJURY	___	___	DIABETES	___	___
SEIZURES	___	___	HIGH BLOOD PRESSURE	___	___
NECK/BACK PAIN	___	___	BLEEDING DISORDER	___	___
FAINTING SPELLS	___	___	THYROID DISORDER	___	___
EYE PROBLEMS	___	___	FRACTURES	___	___
SKIN PROBLEMS	___	___	ASTHMA	___	___
HEART PROBLEMS	___	___	SURGERY	___	___
KIDNEY PROBLEMS	___	___	RECENT/CURRENT HEALTH ISSUES	___	___

FAMILY HISTORY OF SUDDEN CARDIAC DEATH BEFORE AGE 50?_____

*Details to any Yes answers above*_____

_____

ALLERGIES_____

CURRENT MEDICATIONS *(PRESCRIBED & OVER THE COUNTER)*_____

_____

I hereby give permissions for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

SIGNATURE OF PARENT/GUARDIAN_____ DATE_____

TO BE COMPLETED BY PROVIDER:

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE _____ PULSE_____ APPEARANCE_____ SKIN_____

VISION: R 20/_____ L 20/_____ CORRECTED_____ EYES_____ HEARING_____ LYMPH NODES_____

HEART_____ MURMUR_____ LUNGS_____ ABDOMEN_____ HERNIA_____ NEUROLOGIC_____

NECK_____ BACK_____ SHOULDER/ARM_____ ELBOW/FOREARM_____ WRIST/HAND_____

HIP/THIGH_____ KNEE_____ LEG/ANKLE_____ FOOT/TOES_____ FUNCTIONAL_____

*List any abnormal findings*_____

_____

____ Cleared for all sports without restrictions

____ Cleared for all sports with restrictions or recommendations_____

_____

____ Not cleared _____

_____

PROVIDER SIGNATURE_____ DATE_____