Andes Central School

Athletic Health History

Date:_________________

STUDENT:____ DOB: _________________

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

This form must be completed and returned to the Health Office

❑ My child may participate in interscholastic sports

❑ My child may **not** participate in the following interscholastic sports:___________________________

____

❑ My child **will not** be participating on any interscholastic sports team.

___________________________________ ___________________________________

Parent name (please print) Parent signature

If you do not wish your child to participate in interscholastic sports you may stop here. However, please return this form to the Health Office.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

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

	YES	NO
Is there a current medical examination on file in the nurse's office:	❑	❑
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	❑	❑
Has your child been unconscious or lost memory from a blow on the head?	❑	❑

(continue on reverse)

Andes Central School

Athletic Health History

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes…………………………	❑	❑
Severe hearing loss in both ears…………………………………………………………………	❑	❑
One kidney……………………………………………………………………………………………	❑	❑
One testicle…………………………………………………………………………………………	❑	❑
Has your child been ill for five (5) consecutive days?……………………………………	❑	❑

If Yes-____

____

	YES	NO
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?________________________	❑	❑

____

	YES	NO
Is your child under medical care now?………………………………………………………	❑	❑
Has your child taken any medication in the past year?…………………………………	❑	❑

If yes-____

____

____

____

	YES	NO
Is your child taking any medications now?…………………………………………………	❑	❑

If yes-____

____

	YES	NO
Has your child ever fainted during exercise?………………………………………………	❑	❑

If yes-____

	YES	NO
Has there ever been sudden death in a family member under fifty (50) years of age?…….	❑	❑

____

	YES	NO
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?…………………………………………………………………	❑	❑
Does your child have: orthodontic appliances?………………………………………	❑	❑
Capped teeth?………………………………………………………………………………	❑	❑
Wear contact lenses for sports?…………………………………………………………	❑	❑
Wear glasses for sports?…………………………………………………………………	❑	❑
Since your child's **last physical** examination, has your child had any injury or illnesses?..	❑	❑

If Yes-____

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.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE:_______________________________________**Date**:______________________