

SCSD SPORTS HEALTH HISTORY/UPDATE

This form must be completed in full or a physical will not be performed.

NAME: SCHOOL:

ADDRESS: HOME#:

SPORT: LEVEL GRADE: MALE FEMALE

PARENT/GUARDIAN: PLEASE CHECK ANY OF THE CONDITIONS LISTED BELOW THAT YOUR CHILD HAS HAD.

- Allergies-Environmental, Allergies-Food, Medication, Insects, Asthma-Needs Inhaler, Anemia, Arthritis, Back or Neck Pain/Injury, Bladder or Kidney Problem/Injury, Blood or Bleeding Disorder, Chronic Diarrhea or Constipation, Convulsions/Seizures, Diabetes, Elevated Blood Pressure, Eye Disease or Injury, Fainting Spells, Fracture of Dislocated Bone, Headaches-Frequent, Head Injury or Concussion, Heart Disease/Murmur/Chest Pain, Heat Exhaustion or Heat Stroke, High Blood Pressure, Knee, Ankle, Wrist, or Elbow Pain/Injury, Nose Bleeds-Frequent or Severe, Rheumatic Fever, Spleen Injury/Enlargement, Loss of Function in One Kidney, One Testicle, Severe Hearing Loss, Severe Loss of Vision in One Eye, Joint, Ligament or Muscle Injury, Other

GIVE DETAILS REGARDING ANY OF THE ABOVE CONDITIONS

Has there been a death of a family member less than fifty years of age? YES NO

PARENTS/GUARDIANS: PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

- Is your child currently assigned to the Adaptive Physical Education Program? YES NO
Has your child ever fainted during exercise? YES NO
Has your child ever been unconscious or lost memory as a result of a head injury? YES NO
Has your child recently been ill for more than five consecutive days? YES NO
Has your child had any injury/illness that required hospitalization, surgery, x-rays, or emergency care? YES NO
Is your child currently under a physician's care for any medical condition? YES NO
Is your child currently taking any medications? YES NO
Does your child have an orthodontic appliance? YES NO
Does your child have capped teeth, bridges, or partial dentures? YES NO
Does your child wear contact lenses for sports? YES NO
Does your child wear glasses for sports? YES NO
Since your child's last physical exam for participation in sports, has he/she had any injuries/illnesses? YES NO
Do you have any concerns regarding your child's health that you would like to discuss with a physician? YES NO
Does your child urinate frequently? YES NO
Has your child experienced sudden weight loss of more than five to ten pounds? YES NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS AND DATES

Since your last health update for sports participation, has your child had any change in health status or conditions requiring medical treatment?

- If yes, diagnosis of Illness or Injury YES NO
Was hospitalization (including Emergency Room Evaluation) required? YES NO
If surgery was required, please specify YES NO
If yes to any of the above, do you have written clearance to resume all Physical Education? YES NO

If you have had any serious illness or injury since your last physical for sports participation, WRITTEN clearance from the attending physician is required before the school nurse will authorize your participation in any sport.

Date

Student Signature

Date

Parent/Guardian Signature