WHITEHALL CENTRAL SCHOOL
ATHLETIC HEALTH HISTORY

Current Grade: _____

Student's Name:_____ **Date of Birth:**_____

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

SPORTS ACTIVITIES

Identify any sports in which you **DO NOT** want your child to participate: _____

_____

Is there a current physical exam on file in the School Health Office? YES NO

HEALTH HISTORY
TO BE COMPLETED BY PARENT/GUARDIAN

Has your child ever had: (please circle)

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

Is your child under medical care now? YES NO

If YES, what for? _____

Does your child take any medications regularly? YES NO

If YES, please write the name, dose and frequency of each medication:

Name of Medication *Amount and how often taken*

1) _____

2) _____

3) _____

Does your child have any allergies? YES NO

If **YES, PLEASE LIST ALL** allergies to medications, foods, other insects or other substances:

_____

_____

For environmental or bee allergies, please explain how treated: _____

_____

(⇒ Please continue and sign the other side ⇒)

Please list any hospitalizations, accidents, broken bones and/or surgeries:

_____

_____

_____

Has your child been assigned to, or participated in, the Adaptive Physical Education Program? YES NO

Has your child been unconscious or lost memory from a blow to the head? YES NO

If YES, please explain: _____

Does your child have any of the following?:

One eye or severe uncorrectable loss of vision in one or both eyes	YES	NO
Severe hearing loss in one or both ears	YES	NO
One kidney	YES	NO
One testicle	YES	NO

Has your child ever been ill for five (5) consecutive days? YES NO

If YES, please explain: _____

Has your child ever fainted during exercise? YES NO

If YES, please explain: _____

_____

Has there ever been the sudden death of a family member under fifty (50) years old? YES NO

If YES, please explain: _____

Does your child have any of the following?:

Orthodontic appliances/braces	YES	NO
Capped teeth	YES	NO
Wear contact lenses for sports	YES	NO
Wear glasses for sports	YES	NO

Since your child's last physical examination, has your child had any injury or illnesses? YES NO

If YES, please explain: _____

Do you have any questions concerns about your child's health you would like to discuss with a doctor? YES NO

If YES, please explain: _____

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 designated by school authorities.

Parent/Guardian Signature: _____ Date: _____

Rev 3/?007