

**Health History / Physical Evaluation**  
The Health History is to be completed for all students by the parent.

Name _____	Sex _____	Age _____
Date of Birth _____	Phone _____	Grade _____ School _____

<i>Explain "Yes" answers at the bottom of this form.</i>	YES	NO
1. Has your child had a medical illness or injury since their last check up or physical? Does your child have an ongoing or chronic illness? (for example, Diabetes, Kidney Disease) Does your child have a bleeding tendency. (i.e. severe or freq. nosebleeds, dysmenorrhea?) Has your child ever had jaundice? Has your child ever had tuberculosis or a positive skin test for any reason?		
2. Is your child missing one of a paired organ or the function of one of a paired organ? (for example: Eye, Kidney, Lung, Testicle)		
3. Has your child ever been hospitalized overnight? Has your child ever had surgery?		
4. Is your child currently taking any prescription or non-prescription (over-the-counter) medications or using an inhaler?		
5. Does your child have any allergies (for example, to pollen, medicine, food, latex or stinging insects)? <i>Please explain all allergies, including medication information, in detail, below.</i>		
6. Has your child ever passed out or been dizzy during or after exercise? Does your child get tired more quickly than their friends during exercise? Has your child ever had their heart race or skip heartbeats? Has your child had high blood pressure or high cholesterol? Has your child ever been told they have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Has your child had a severe viral infection (for ex: myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your child's participation in physical activity or sports for any heart problems?		
7. Does your child have any current skin problems - for example, itching, rashes, acne, warts, fungus or blisters?		
8. Has your child ever had a head injury or concussion? Has your child ever been knocked out, become unconscious, or lost their memory? Has your child ever had a seizure? Does your child have frequent or severe headaches? Has your child ever had numbness or tingling in their arms, hands, legs, or feet? Has your child ever had a stinger, burner, or pinched nerve?		
9. Has your child ever become ill from exercising in the heat?		
10. Does your child cough, wheeze, or have trouble breathing during or after activity? Does your child have asthma? Does your child have seasonal allergies that require medical treatment?		
11. Does your child use any special protective or corrective equipment or devices that aren't usually used for regular physical activity, sports or position (for example, knee brace, special neck roll, foot orthotics, retainer on their teeth, hearing aid)?		
12. Has your child had any problems with their eyes or vision? Does your child wear glasses, contact lenses or protective eyewear?		
13. Does your child have any difficulty hearing?		
14. Has your child ever had a sprain, strain or swelling after injury? Has your child ever broken or fractured any bones or dislocated any joints? Has your child had any other problems with pain or swelling in muscles, bones, or joints?		

If yes, check appropriate box and explain below:

<input type="checkbox"/>	Ankle	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Foot	<input type="checkbox"/>	Knee	<input type="checkbox"/>	Shoulder
<input type="checkbox"/>	Arm	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Hand	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Thigh
<input type="checkbox"/>	Back	<input type="checkbox"/>	Finger	<input type="checkbox"/>	Head	<input type="checkbox"/>	Shin / Calf	<input type="checkbox"/>	Wrist

Explanation of these injuries:

*Explain 'YES' answers here:*

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of parent/guardian _____	Date _____
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