**Tamarac Secondary School requires an Athletic Health History form be completed for each student athlete. This form is only required to be filled out once and will remain on file for the athlete's entire school career.**

Physical will be conducted on: Grade _____
Date_______________
Time_______________

# ATHLETIC HEALTH HISTORY

**SCHOOL NAME:**_______________________________________________

**STUDENT:**_________________________________DOB: ______________

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 wish your child to participate:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

## THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL HEALTH OFFICE AS SOON AS POSSIBLE

### HEALTH HISTORY
### TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

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

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

Does your child have any of the following:

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

______________________________________________

______________________________________________

| | | |
|---|---|---|
| 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?______________________ | o | o |

______________________________________________

| | | |
|---|---|---|
| Is your child under medical care now?.......................................................... | o | o |
| Has your child taken any medication in the past year?........................................ | o | o |

If so, why?______________________________________________

______________________________________________

______________________________________________

______________________________________________

| | | |
|---|---|---|
| Is your child taking any medications now?.................................................... | o | o |

If so, why?______________________________________________

______________________________________________

| | | |
|---|---|---|
| Has your child ever fainted during exercise?.................................................. | o | o |

If so, explain.______________________________________________

| | | |
|---|---|---|
| Has there ever been sudden death in a family member under fifty (50) years of age?....... | o | o |

______________________________________________

| | | |
|---|---|---|
| Do you have any worries about your child's health or other questions you would like to discuss with a doctor?................................................................ | o | o |
| Does your child have: orthodontic appliances?.................................................. | o | o |
| Capped teeth?................................................................................ | o | o |
| Wear contact lenses for sports?................................................................ | o | o |
| Wear glasses for sports?...................................................................... | o | o |
| Since your child's last physical examination, has your child had any injury or illnesses?.. | o | o |

______________________________________________

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:**____________________