

HEALTH RECORD AND QUESTIONNAIRE PARENT / GUARDIAN CONSENT

Pages 1-5 must be completed and signed by parent or guardian.

Date: _____

PERSONAL INFORMATION

Name _____ Date of Birth _____ Age on Last Birthday _____

Current Address _____

Current Phone # () _____

Resident of _____ Public School District Enrolled in _____ School

Family Physician _____

Address and Phone # _____

GENERAL INFORMATION

Does the student have or have a history of the following:

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Problems _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Chest Pain/Angina _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Extra Heart Beat _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Black Outs/Loss of Consciousness _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Rheumatic Fever _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Allergies _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Medication _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Food _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Bites/Stings _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	High Blood Pressure _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Drug or Alcohol Problems _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Cysts or Lumps _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Heat Cramps/Exhaustion/Stroke _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Skin Problems (itching, rashes, or acne) _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Infectious Mononucleosis (Mono) _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Loss of Paired Organ (i.e. eye, testicle) _____

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Does the student wear glasses or contact lenses? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Any special protective equipment needs? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Does the student take any medications? _____
		If so, over-the-counter, prescription, herbal or dietary supplements? (circle all that apply)
		Medications: _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Has the student ever used anabolic steroids? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Has the student ever used extreme measures to avoid gain or loss of weight? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Weight change in last six months? How Much _____ Up or down _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Has the student ever had surgery? _____
		If so, when and what? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Has the student ever had varicella (chicken pox)? _____
		When was the student's last tetanus shot? ____ Measles shot x 2 _____ Hepatitis B Vaccination x 3 _____

ABDOMINAL

Does the student have or have a history of the following:

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Appendicitis _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach Trouble _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Bleeding from Rectum _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Injury to Spleen _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Hernia _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Injury to Kidney _____

Are the following organs intact and normal as far as you know?

(Indicate absence of organs)

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Lungs _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Kidneys _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Testes _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Eyes _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ears _____

NEUROLOGICAL

Does the student have or have a history of the following:

YES	NO	EXPLAIN
		Head Injury
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Skull Fracture _____
		How many concussions total? _____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Concussion (memory loss, headache, confusion, nausea) _____
		Last concussion was _____ months ago?
		How long did concussion last? _____

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Unconsciousness _____ How long were you out? _____minutes/seconds
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neck Injury _____ Fracture _____ What spinal level? _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve (Burner or Stingers) _____ Left _____ or Right _____ or Both _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches _____ How often? _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety _____

EAR-NOSE-THROAT

Does the student have or have a history of the following:

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hearing difficulty _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent Earache _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Problems Breathing through Nose _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Broken Nose _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent Tonsil Infection _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cough after or during Exercise _____

DENTAL

Does the student have or have a history of the following:

YES	NO	EXPLAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cavities _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	False Teeth _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Many Toothaches _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Missing Teeth _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Does the student Have A Dentist? _____

FEMALES

YES NO EXPLAIN

Does the student have a history of eating disorder. _____

First menstrual period was at age _____. Last menstrual period was _____ days ago.

The longest time between periods over the last year was _____ months.

Periods last _____ days.

Is the student pregnant? _____

FAMILY HEALTH HISTORY

Has any member of the student's family died from or now have any of the following:

YES

NO

EXPLAIN (RELATION AND AGE)

Died Suddenly _____

Heart Disease _____

Diabetes _____

High Blood Pressure _____

Seizure Disorder _____

Sickle Cell Trait/Disease _____

Has the student had any other medical conditions not listed? _____

If yes, explain _____

ORTHOPEDIC

Does the student have or have a history of any injury to any of the following: (Please explain whether the injury was right or left, the month and year of the injury and if the injury fully recovered or not.)

YES

NO

EXPLAIN

Cervical Spine

Fracture _____

Pinched Nerve _____

Stinger/Burner _____

Thoracic Region

Upper Back _____

Chest, Ribs _____

Lumbar Spine (Lower Back)

Muscle spasm, strain _____

Fracture or other _____

Shoulders _____

Upper Arm/Elbow _____

Forearm/Wrist _____

Hand/Fingers _____

Pelvis/Hip/Groin _____

Thigh: Quadriceps _____

Name _____

YES

NO

EXPLAIN

Y

N

Hamstrings _____

Y

N

Other _____

Y

N

Knees _____

Y

N

Lower Leg/Ankle _____

Y

N

Calf/Shin _____

Y

N

Achilles Tendon _____

Y

N

Ankle _____

Y

N

Foot/Toes _____

Y

N

Diagnostic Tests: Bone Scan _____

CAT Scan _____

MRI Scan _____

X-Rays _____

Ultrasound _____

Other _____

Y

N

Has the student had any other injuries to bones, joints, muscles or nerves (dislocations, tendinitis, calcium deposits, fractures, spurs, etc.) not listed herein?

If yes, explain _____

Y

N

I certify that to the best of my knowledge all of the information herein is True and Complete.

Y

N

I grant permission for medical personnel, at their discretion, to release my child's school health record medical information, including information from the Health Record and Questionnaire and physical evaluation, to those individuals deemed necessary by the medical personnel.

Y

N

I give my consent for the student named herein to commence practice and participate in athletic contests during the _____ school year in the sport(s) of _____

Parent/Guardian Signature _____ Date ____/____/____