

HEALTH HISTORY

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:

**HEALTH HISTORY
 TO BE COMPLETED BY PARENT**

Has your child ever had: (please check)

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

Is there a current medical examination on file in the nurse's office: YES NO

Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education? YES NO

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

Does your child have any of the following:

- One eye or severe uncorrectable loss of vision in one or both eyes.....
- Severe hearing loss in both ears.....
- One kidney.....
- One testicle.....
- Has your child been ill for five (5) consecutive days?.....

 _____ (over)

Does your child have any of the following:	YES	NO
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? _____ _____	<input type="radio"/>	<input type="radio"/>
Is your child under medical care now?.....	<input type="radio"/>	<input type="radio"/>
Has your child taken any medication in the past year?.....	<input type="radio"/>	<input type="radio"/>
If so, why? _____ _____		
Is your child taking any medications now?.....	<input type="radio"/>	<input type="radio"/>
If so, why? _____ _____		
Has your child ever fainted during exercise?.....	<input type="radio"/>	<input type="radio"/>
If so, explain. _____		
Has there ever been sudden death in a family member under fifty (50) years of age?.....	<input type="radio"/>	<input type="radio"/>
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?.....	<input type="radio"/>	<input type="radio"/>
Does your child have: orthodontic appliances?.....	<input type="radio"/>	<input type="radio"/>
Capped teeth?.....	<input type="radio"/>	<input type="radio"/>
Wear contact lenses for sports?.....	<input type="radio"/>	<input type="radio"/>
Wear glasses for sports?.....	<input type="radio"/>	<input type="radio"/>
Since your child's last physical examination, has your child had any injury or illnesses?..	<input type="radio"/>	<input type="radio"/>

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:** _____

KEENE CENTRAL SCHOOL

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This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

Any unmarked categories indicates disqualification from the particular group of sports activities.

CONTACT/COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NONCONTACT	NONSTRENUOUS NONCONTACT
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Field Hockey
Football
Ice Hockey
Lacrosse
Soccer
Wrestling

Baseball
Basketball
Diving
Gymnastics
Handball
Skiing-Cross Country
Skiing-Downhill
Softball
Volleyball

Crew
Cross-country
Track and Field
Swimming
Tennis

Archery
Bowling
Golf
Riflery

Physician's Signature

Date