GREENE CENTRAL SCHOOL
ATHLETIC HEALTH HISTORY

Name_____ **Date of Birth** _____ **Grade**_____

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:

_____

_____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE NURSES OFFICE AS SOON AS POSSIBLE.

HEALTH HISTORY
TO BE COMPLETED BY PARENT/GUARDIAN

Has your child ever had (please check):

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

	Yes	No
Is there a current medical examination on file in the nurse's office?	☐	☐
Is your child assigned to the Adaptive Physical Education Program or has he/she been in an Adaptive Physical Education?	☐	☐
Has your child been unconscious or lost memory from a blow on the head?	☐	☐
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?	☐	☐

Please turn page over

Does your child have any of the following:	**Yes**	**No**
One kidney?	☐	☐
One Testicle?	☐	☐
Has your child been ill for five (5) five consecutive days?	☐	☐

Please describe: _____

_____

	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; or caused your child to miss a game or practice? Please describe:	☐	☐

_____

_____

	Yes	**No**
Is your child under medical care now?	☐	☐
Has your child taken any medication in the past year?	☐	☐

If yes, why? _____

_____

	Yes	**No**
Is your child taking any medication now?	☐	☐

If yes, why? _____

_____

	Yes	**No**
Has your child ever fainted during exercise?	☐	☐

If yes, explain: _____

_____

	Yes	**No**
Has there ever been sudden death of a family member under fifty (50) years of age?	☐	☐

Please describe: _____

	Yes	**No**
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?	☐	☐
Does your child have orthodontic appliances?	☐	☐
Capped Teeth?	☐	☐
Wear contact lenses for sports?	☐	☐
Wear glasses for sports?	☐	☐
Since your child's last physical examination has your child had any injury or medical illness?..	☐	☐

If yes, explain: _____

_____

I agree with the above answers and consent to participation of my child in the interscholastic program of Greene Central School including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent Signature: _____ Date_____