

Ticonderoga Central Schools

Athletic Health History

Name: _____ Sport: _____

Age: _____ Grade: _____ Date of Birth: _____

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 before the athlete has his/her physical.

HEALTH HISTORY

(To be completed by parent)

Has your child ever had: (Please check)

	Yes	No
Allergies/Hay Fever		
Bee Sting Allergy		
Asthma		
Anemia		
Arthritis		
Bladder/Kidney Problem or Injury		
Convulsions/Seizures		
Fainting Spells		
Diabetes		
Ear Problems/Hearing Loss		
Eye Problems/Vision Loss		
Injury to the Spleen		
Joint Sprain/Ligament Tear/Muscle Pull		

	Yes	No
Elevated Blood Pressure		
Headaches		
Head Injury/Concussion		
Heart Problem/Murmur-Chest Pains		
Nose Bleeds/Frequent or Severe		
Ankle Injury		
Back Pain/Injury		
Fracture-Dislocation Bones/Joints		
Knee Pain/Injury		
Neck Injury		
Nose Fracture		
Rheumatic Fever		
Stomach Ulcer		

Has your child been unconscious or lost memory from a blow on the head? _____

Does your child have any of the following: _____ Yes | No

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? _____

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 for x-rays; required an operation; caused your child to miss a game or practice? _____

		Yes	No
Is your child under medical care now? _____			
Has your child taken any medication in the past year? _____			
Please List Meds::: _____			

Is your child taking any medication now? _____			
Please List Meds::: _____			

Has your child ever fainted during exercise? _____			
If so, explain. _____			
Has there ever been sudden death of a family member under fifty (50) years of age? _____			

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? _____			

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 athletic contests.

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

Parent Signature: _____ Date: _____

If you have any questions regarding the physical exam given by the school physician, please contact:

Middle School Nurse - 585-7442, Ext. 213
High School Nurse - 585-6661, Ext 124

Additional Comments:
