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:

School Nurse - 585-**7400** Ext 1114

Additional Comments:

_____

_____

_____

(5/7/03)