

Cohoes City School District

Please circle yes or no: My child will obtain physical from own physician . YES NO
OR

My child will receive physical at school on _____ . YES NO

GRADE _____ SPORT _____

ATHLETIC HEALTH HISTORY

SCHOOL NAME: _____

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="checkbox"/>	<input type="checkbox"/>	Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bee Sting Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem/Murmur-Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/Frequent or Severe	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/Kidney Problem or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Injury	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fracture-Dislocation Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems/Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems/Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Nose Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Injury to the Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Joint Sprain/Ligament Tear/Muscle Pull	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>

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?

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

(over)

Does your child have any of the following:

- | | YES | NO |
|---|--------------------------|--------------------------|
| One eye or severe uncorrectable loss of vision in one or both eyes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe hearing loss in both ears..... | <input type="checkbox"/> | <input type="checkbox"/> |
| One kidney..... | <input type="checkbox"/> | <input type="checkbox"/> |
| One testicle..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child been ill for five (5) consecutive days?..... | <input type="checkbox"/> | <input type="checkbox"/> |

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?..... YES NO

Is your child under medical care now?..... YES NO
Has your child taken any medication in the past year?..... YES NO
If so, why?.....

Is your child taking any medications now?..... YES NO
If so, why?.....

Has your child ever fainted during exercise?..... YES NO
If so, explain.....
Has there ever been sudden death in a family member under fifty (50) years of age?..... YES NO

- Do you have any worries about your child's health or other questions you would like to discuss with a doctor?..... YES NO
- Does your child have: orthodontic appliances?..... YES NO
- Capped teeth?..... YES NO
- Wear contact lenses for sports?..... YES NO
- Wear glasses for sports?..... YES NO
- Since your child's last physical examination, has your child had any injury or illnesses?.. YES NO

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:** _____