

# IMMACULATE CONCEPTION SCHOOL

## ATHLETIC HEALTH HISTORY

### GRADE 4-6

Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Phone (include-home, work, cell) \_\_\_\_\_

Participation in athletics is voluntary and is not a required part of the regular physical education program.

**THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR CHILD'S SCHOOL PHYSICAL.**

#### HEALTH HISTORY TO BE COMPLETED BY PARENT

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 Problems/Murmur/Chest pain  | ___ | ___ |
| Arthritis                              | ___ | ___ | Nose Bleeds/Frequent or Severe    | ___ | ___ |
| Bladder/Kidney Problems or Injury      | ___ | ___ | Ankle Injury                      | ___ | ___ |
| Convulsions/Seizures                   | ___ | ___ | Back Pain/ Injury                 | ___ | ___ |
| Fainting Spells                        | ___ | ___ | Fracture/Dislocation Bones/Joints | ___ | ___ |
| Diabetes/ low blood sugar              | ___ | ___ | Knee Pain/Injury                  | ___ | ___ |
| Ear Problems/Hearing Loss              | ___ | ___ | Neck Injury                       | ___ | ___ |
| Eye Problems/Vision Loss               | ___ | ___ | Nose Fracture                     | ___ | ___ |
| Injury to Spleen                       | ___ | ___ | Rheumatic Fever                   | ___ | ___ |
| Jaundice                               | ___ | ___ | Seizures                          | ___ | ___ |
| Joint Sprain/Ligament Tear/Muscle Pull | ___ | ___ | Stomach Ulcer                     | ___ | ___ |

If you answered yes to any question above, please explain. \_\_\_\_\_  
 \_\_\_\_\_

Does your child have any of the following?

Missing one of a paired organ: ie. eye, kidney, lung, testicle \_\_\_\_\_  
 If yes please explain \_\_\_\_\_

Has your child ever had an illness, condition, or injury that required him/her to be hospitalized or required a trip to the emergency room?

Is your child under medical care now?... If so please explain. \_\_\_\_\_  
 \_\_\_\_\_

Is your child taking any medication now? \_\_\_\_\_  
 If so, what? \_\_\_\_\_  
 \_\_\_\_\_

OVER

Yes No

Have you ever had your activities restricted or sports participation denied by a physician?  
Please explain. \_\_\_\_\_

Do you have any worries about your child's health that you would like addressed?..... \_\_\_\_\_

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 illness or injury?..... \_\_\_\_\_

In the past year has your child had a significant weigh gain \_\_\_\_\_/weight loss \_\_\_\_\_?

I state that the to best of my knowledge the answers to the above questions are complete and correct. In the event of an emergency and I cannot be reached, I agree to emergency treatment as deemed necessary by the physicians designated by the school authorities.

I give my consent for my child to participate in the interscholastic program of Immaculate Conception School including practice sessions and athletic contests.

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_