INTERVAL ATHLETIC HEALTH HISTORY

PARENTS -PLEASE FILL OUT COMPLETELY-TOP TO BOTTOM AND SIGN.

COMPLETE NO MORE THAN 30 DAYS PRIOR TO PARTICIPATION IN EACH ATHLETIC SPORTS SEASON.

NAME: _____ GRADE: _____ SPORT: _____

QUESTION	YES	NO	QUESTION	YES	NO
1. Any heart problems in family under the age of 50?			6. Any chronic illness such as asthma, allergies, diabetes or seizures?		
2. Hypertension, cardiac arrhythmias or heart murmur?			7. Presently taking any medication?		
3. Any fainting spells during exercise?			8. Weight gain or loss of more than 10-20 lbs?		
4. Ever fall unconscious after a head injury? Concussions? How many?			9. Under the care of a Dr.?		
5. Any illness in the last 6 months lasting longer than 1 week?			10. Any reason why this person may not participate in any sport?		

If answered "yes" to any of the above please describe: _____

_____

We understand clearly that the questions are asked in order to decide if this student is in a proper condition to participate in the athletic activity named at the top of this form. The answers are correct as of the date this form is signed. All answers will be kept confidential.

SIGNATURE OF PARENT/GUARDIAN	DATE	SIGNATURE OF STUDENT	DATE

*NOTE: "YES" answer to any of the above questions does not mean automatic disqualification from the athletic activity indicated. They will require review and evaluation by the school Physician.

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PERMISSION TO ENTER

_____ _____ _____

SPORT (Jr. H.-JV-V) DATE OF BIRTH SCHOOL YEAR

NAME: _____ MEDICAL HISTORY: _____

ADDRESS: _____ _____

PARENTS' NAME: _____ _____

HOME PHONE _____ WORK _____

EMERGENCY # _____

_____ _____

DATE NURSE'S SIGNATURE