

HEALTH SCREENING/MEDICAL UPDATE

Both pages must be completed

Date:

Student Name:	DOB:
School Name:	Age:
Grade:	Sport:
Date of last health exam:	

Health History To Be Completed By Parent/Guardian, Provide Details to Any Yes Answers on Back

Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:

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General Health Concerns	Yes or No	Devices/Accommodations	Yes or No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		22. Use a brace, orthotic or other device?	
2. Have an ongoing medical condition? __Asthma, __Diabetes, __Seizures, __Sickle Cell trait or disease, Other_____		23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	
3. Ever had surgery?		24. Wear protective eyewear, such as goggles or a face shield?	
4. Ever spent the night in a hospital?		Family History Yes or No	
5. Been diagnosed with Mononucleosis within the last month?		25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome or catcholamingeric polymorphic ventricular tachycardia?	
6. Have only one functioning kidney?		Females Only Yes or No	
7. Have a bleeding disorder?		26. Begun having her period?	
8. Have any problems with his/her hearing or wears hearing aid(s)?		27. Age period began:	
9. Have any problems with his/her vision or has vision in only one eye?		28. Have regular periods?	
10. Wear glasses or contacts?		29. Date of last menstrual period:	
Allergies Yes or No		Males Only Yes or No	
11. Have a life threatening allergy ? If yes, please specify:		30. Have only one testicle?	
12. Carry an epinephrine auto-injector?		Heart Health Yes or No	
Breathing (Respiratory) Health Yes or No		31. Have groin pain or a bulge or hernia in the groin?	
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		32. Ever passed out during or after exercise?	
14. Wheeze or cough frequently during or after exercise?		33. Ever complained of light headedness or dizziness during or after exercise?	
15. Ever been told by their health care provider they have asthma?		34. Ever complained of chest pain, tightness or pressure during or after exercise?	
16. Use or carry an inhaler or nebulizer?		Concussion/Head Injury History Yes or No	
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have pacemaker?	
18. Have you ever had a head injury or concussion?		36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?	
19. Ever had headaches with exercise?			
20. Ever had any unexplained seizures?			
21. Currently receive treatment for a seizure disorder or epilepsy?			

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School Name:	Age:

Heart Health <i>continued</i>	Yes or No	Skin Health	Yes or No
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply		43. Currently have any rashes, pressure sores, or other skin problems?	
		44. Have had a herpes or MRSA skin infections?	
Heart Infection		Stomach Health	
Heart Murmur		Yes or No	
High Blood Pressure		45. Ever become ill while exercising in hot weather?	
Low Blood Pressure		46. Have a special diet or have to avoid certain foods?	
High Cholesterol		47. Have to worry about his/her weight?	
Kawasaki Disease		48. Have stomach problems?	
Other		49. Have you ever had an eating disorder?	
Injury History		Yes or No	
38. Ever been diagnosed with a stress fracture?			
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?			
40. Ever had an injury, pain or swelling of joint that caused him/her to miss practice or a game?			
41. Have a bone, muscle or joint injury that bothers him/her?			
42. Have joints become painful, swollen, warm, or red with use?			

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known)

Parent/Guardian Signature:	Date:
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