FORT PLAIN CENTRAL SCHOOL DISTRICT
25 HIGH STREET
FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE" | TELEPHONE 518-993-4000

Grade: _____

FORT PLAIN JUNIOR/SENIOR HIGH SCHOOL ATHLETIC HEALTH HISTORY

Student Name:_____ 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. A urinalysis must also be done for kidney function.

HEALTH HISTORY TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	O	O	Back Pain/Injury	O	O
Elevated Blood Pressure	O	O	Fainting Spells	O	O
Bee Sting Allergy	O	O	Fracture-Dislocation-Bones/Joints	O	O
Headaches	O	O	Diabetes	O	O
Asthma	O	O	Knee Pain/Injury	O	O
Head Injury/Concussion	O	O	Ear Problems/Hearing Loss	O	O
Anemia	O	O	Neck Injury	O	O
Heart Problem/Murmur-Chest pain	O	O	Eye Problems/Vision Loss	O	O
Arthritis	O	O	Nose Fracture	O	O
Nose Bleeds/Frequent or Severe	O	O	Injury to the Spleen	O	O
Bladder/Kidney Problem or Injury	O	O	Rheumatic Fever	O	O
Ankle Injury	O	O	Joint Sprain/Ligament Tear/Muscle Pull	O	O
Convulsions/Seizures	O	O	Stomach Ulcer	O	O

	YES	NO
Is there a current medical examination on file in the nurse's office:	O	O
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	O	O
Has your child been unconscious or lost memory from a blow on the head?	O	O

(over)

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes	O	O
Severe hearing loss in both ears	O	O
One kidney	O	O
One testicle	O	O
Has your child been ill for five (5) consecutive days?	O	O

Has your child ever had an illness, condition, or injmy that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required n operation; caused your child to miss a game or practice? . . . . . O . . . . . O

Is your child under medical care now? . . . . . O . . . . . O
Has your child taken any medication in the past year?. . . . . O . . . . . O
If so, why?_____

_____

Is your child taking any medications now?. . . . . O . . . . . O
If so, why?_____

_____

Has your child ever fainted during exercise? . . . . . O . . . . . O
If so, explain: _____

Has there ever been sudden death in a family member under fifty (50) years of age? . . . . . O . . . . . O

Do you have any worries about your child's health or other questions you would like to discuss with a doctor? . . . . . O . . . . . O
Does your child have: orthodontic appliances? . . . . . O . . . . . O
Capped teeth? . . . . . O . . . . . O
Wear contact lenses for sports? . . . . . O . . . . . O
Wear glasses for sports? . . . . . O . . . . . O
Since your child's last physical examination, has your child had any injury or illnesses? . . . . . O . . . . . O

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_____