



ATHLETIC HEALTH HISTORY

New York State law requires that each year, in order for a student to participate in athletic competition, an Athletic Health History Form must be completed and signed by a parent/guardian, and that a physical examination be done by a school doctor.

The school doctor will not perform the physical examination without this completed and signed Athletic Health History Form.

This Athletic Health History Form must be completed, signed by a parent/guardian and returned to the School Nurse.

NAME _____ BIRTH DATE _____

SCHOOL _____ GRADE _____ HOME ROOM _____

Please answer **all** questions.

Does your child have a history of:

	YES	NO		YES	NO
Allergies/Hayfever	___	___	Head injury/Loss of consciousness	___	___
Bee sting allergy	___	___	Headaches	___	___
Anemia	___	___	Heart disease including	___	___
Arthritis	___	___	chest pain or murmurs	___	___
Asthma	___	___	Hernia	___	___
Back/Neck injury	___	___	Injury to: Bones	___	___
Bladder/Kidney disease	___	___	Joints	___	___
Bleeding (incl. Nose bleeds)	___	___	Muscle	___	___
Blood Pressure changes	___	___	Spleen	___	___
Cancer/Leukemia	___	___	Lung disease	___	___
Convulsions/Seizures	___	___	Missing Kidney	___	___
Depression	___	___	Missing Testicle	___	___
Diabetes	___	___	Rheumatic Fever	___	___
Ear problems/Hearing Loss	___	___	Surgery	___	___
Eye problems/Vision loss	___	___	Shortness of breath during exercise	___	___
Fainting episode	___	___	Other: Explain below	___	___

Please give details and dates to any questions to which you answered **YES** _____

Has your child ever had an illness, accident, injury or condition that required him/her to be seen in an emergency room?
YES ___ NO ___

If YES please give details and dates _____



CITY SCHOOL DISTRICT OF NEW ROCHELLE

Is your child under medical care now: YES ___ NO ___

If YES please give details and dates _____

Is your child taking medications now or has s(he) taken any within the past year? YES ___ NO ___

If YES please give details and dates _____

Does your child have:

- Capped teeth YES ___ NO ___
- Contact lenses YES ___ NO ___
- Glasses for sports YES ___ NO ___
- Orthodontic appliance YES ___ NO ___

Girls: Age of onset of periods _____ years
Date of first day of last menstrual period _____

Is there any medical condition in your child's **family history** which the school doctor should be aware of prior to clearance for sports? YES ___ NO ___

If YES please give details and dates _____

The above medical History is complete and accurate to the best of my knowledge.

Signature of Parent/Guardian _____ Date _____

Home phone _____ Cell phone _____

Work phone _____

PLEASE NOTE: A student cannot be approved for sports if there has been an illness, accident, injury or surgery until a medical clearance report by the treating physician is received by the school Health Office. The school doctor will review this report and give the final medical clearance for the student to participate in sports.