

# Carmel Central School District Athletic Health History

To Be Completed By Parent/Guardian

School \_\_\_\_\_ Athlete's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Grade \_\_\_\_\_

**Has your child ever had: (please check)**

	Yes	No		Yes	No
Seasonal Allergies/Hay fever			Headaches		
BEE STING ALLERGY			Head Injury / Concussion		
OTHER ALLERGY (IE. PEANUT) PLEASE LIST:			Has your child ever been unconscious or lost memory from a blow to the head?		
Asthma			Nose Bleeds / Frequent or Severe		
Anemia			Heart Problems: Murmur-Chest Pains		
Arthritis			Elevated Blood Pressure		
Bladder/Kidney Problem/Injury			Ankle Injury            R            L		
Convulsions / Seizures			Fracture / Dislocation    Bones / Joints		
Fainting Spells			Knee Pain / Injury       R            L		
Diabetes			Back Pain / Injury		
Ear Problems / Hearing Loss			Neck Injury		
Eye Problems / Vision Loss			Nose Fracture		
Injury to spleen			Rheumatic Fever		
Joint Sprain / Ligament Tear / Muscle Pull			Stomach Ulcer		
Is your child assigned to the Adaptive Physical Education Program, or has he/she ever been in an Adaptive Physical Education Program?					

**Does your child have any of the following? (Please circle)**

- |   |     |    |
|---|-----|----|
| Does your child have one eye or <i>Severe Uncorrectable</i> loss of vision in one or both eyes?   | YES | NO |
| Does your child have a severe hearing loss in both ears?  | YES | NO |
| Does your child have one kidney?  | YES | NO |
| Does your child have one testicle?  | YES | NO |
| Has your child ever had an illness, condition, or injury that required him/her to go to the hospital, either as an overnight patient or in the emergency room for x-rays? | YES | NO |
| If Yes, Explain: _____  |     |    |
| Is your child under medical care now?   | YES | NO |
| If Yes, Explain: _____  |     |    |
| Is your child taking any medication now?  | YES | NO |
| If Yes, Explain: _____  |     |    |
| Has your child ever fainted during exercise?  | YES | NO |
| If Yes, Explain: _____  |     |    |
| Has there ever been a sudden death in a family member under 50 years of age?  | YES | NO |
| If Yes, Explain: _____  |     |    |
| Do you have any worries about your child's health or other questions you would like to discuss with a Doctor?   | YES | NO |
| Does your child have orthodontic appliances?  | YES | NO |
| Does your child have capped teeth?  | YES | NO |
| Does your child wear contact lenses for sports?   | YES | NO |
| Does your child wear glasses for sports?  | YES | NO |
| Since your child's last physical examination, has he/she had any injury or medical illness?   | YES | NO |
| If Yes, Explain: _____  |     |    |

**Choose only ONE sport per season in which you give your child permission to participate in: (Please Circle)**

FALL-GIRLS	FALL-BOYS	WINTER-GIRLS	WINTER-BOYS	SPRING-GIRLS	SPRING-BOYS
FIELD HOCKEY	FOOTBALL	SKIING	SKIING	SOFTBALL	BASEBALL
SOCCER	SOCCER	BASKETBALL	BASKETBALL	TRACK & FIELD	TRACK & FIELD
CROSS COUNTRY	CROSS COUNTRY	GYMNASTICS	WRESTLING	LACROSSE	LACROSSE
VOLLEYBALL		CHEERLEADING	ICE HOCKEY	GOLF	GOLF
TENNIS		BOWLING	BOWLING		TENNIS
CHEERLEADING		TRACK	TRACK		

**PLEASE NOTE: 1-Your child will need a new Health History form prior to the start of each season.**

**2-MEDICAL CLEARANCE MAY BE REQUIRED FOR NEW OR EXISTING CONDITIONS**

**Indigenous to athletics is the possibility of minor injury, and in the extreme, severe injury and even death. It is understood that Carmel School District will provide proper equipment and training, as well as safe facilities, in order to minimize these risks. By my signature below, I agree to let the coach and/or administration administer proper first aid, contact emergency medical services if deemed necessary, and to contact me at the earliest opportunity.**

**Parents Signature:** \_\_\_\_\_ **Parents Phone #:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_