HEALTH HISTORY – To be completed by parent

STUDENT: ____

	Yes	No	Explain
Allergies			
Anemia			
Arthritis			
Asthma			
Bladder/Kidney Problem			
Cardiac Problems: Arrhythmia/Murmur/chest pain			
Convulsions/Seizures			
Diabetes			
Elevated Blood Pressure			
Ear problems/Hearing Loss			
Eye Problems/Vision Loss			
Fainting Spells			
Fracture/Dislocation Bones			
Headaches			
Head Injury/Concussion			
Injury to Spleen			
Joint/Sprain/Ligament Injury			
Nose Bleeds/Frequent or Severe			
Rheumatic Fever			
Stomach Ulcer			

	Yes	No
Has your child been unconscious or lost memory from a blow to the head?		
One kidney…….		
One testicle……		
Has your child been ill for five (5) consecutive days in the past year? If yes please explain -		
Is your child taking any medications now?…… If so, what		
Has your child ever fainted during exercise?…… If so, explain….		
Has there ever been sudden death in a family member under fifty (50) years of age?……. If so, explain….		
Does your child have: orthodontic appliances?		
Capped teeth?		
Wear glasses or contact lenses for sports?		
Wear a hearing aid for sports?		
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?		

I give my child permission to have a physical in school.

PARENT SIGNATURE:_______________________________________**Date**:______________________

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