MEDICAL EXAMINATION - ATHLETICS

PARENTS MEDICAL HISTORY
FOR ATHLETICS

Name ____

PARENT: ____

Current status of student's health:

Allergies? Yes___ No___ If so, describe ____________________

Contact lenses, glasses, teeth braces, or any prosthesis (artificial tooth, limbs, etc.) Yes___ No___ If so, describe ____________________

Long-term prescribed medications? Yes___ No___ If so, describe ____________________

Describe any other significant medical or health problems (asthma, diabetes, epilepsy, heart condition, kidney problems, etc.) ____

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Previous history of health:

Convulsions: Yes___ No___ If so, describe ____________________

Head injuries: Yes___ No___ If so, describe ____________________

Prior athletic injuries: Yes___ No___ If so, describe ____________________

Fractures: Yes___ No___ If so, describe ____________________

Serious or chronic illness: Yes___ No___ If so, describe ____________________

Describe any other significant medical or health problems ____________________

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