

Stillwater Health History for Athletics Confidential

Student Name:		DOB:
School Name:		Age:
Grade(check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Level(check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	
Sport:	Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last health exam:	Date form completed:	

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	Yes	No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis Within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her Hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision Or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies	Yes	No
11. Have a life threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?		
Breathing(Respiratory)Health	Yes	No
13. Ever complained of getting more tired Or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or After exercise?		
15. Ever been told by their healthcare Provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/Head Injury History	Yes	No
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a Seizure disorder or epilepsy?		
Devices/Accommodations	Yes	No
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?If yes there may be need for another required form to be filled out.		
24. Wear protective eye wear, such as Goggles or a face shield?		
Family History	Yes	No
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardio myopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	Yes	No
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	Yes	No
30. Have only one testicle?		
31. Have groin pain or a bulge or herniain The groin?		

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School Name: _____

DOB: _____

Has/Does your child:

Heart Health	Yes	No
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or Dizziness during or after exercise?		
34. Ever complained of chest pain, Tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by their medical Provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History	Yes	No
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:

Injury History <i>continued</i>	Yes	No
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of Joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	Yes	No
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	Yes	No
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or have to avoid Certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.)

Parent/Guardian Signature: _____ Date: _____