THE CHILD SCHOOL/LEGACY HIGH SCHOOL
SPORTS PARTICIPATION HEALTH FORM

This evaluation is only used to determine readiness for sports participation. It should not be used for regular health maintenance examinations which must be on file with the nurse's office. THIS MUST BE COMPLETED BY PARENT AND STUDENT.

NAME _____ _____ AGE_____ SEX _____ GRADE _____
ADDRESS_____ PHONE _____
SPORTS PLAYED (1)_____(2) _____(3)_____(4)_____

MEDICAL HISTORY
(To be completed by student and parent and guardian)

1. Do you have any allergies? (drugs, food, insect stings, etc.)
   _____Yes: List _____ _____ No
2. Are you currently taking any drugs or medications including steroids or protein supplements?
   _____ Yes: List _____ _____ No
3. Are you presently being treated for any condition by a physician or other health care professional?
   _____Yes: Explain _____ _____ No
4. Have you ever been advised by a doctor not to participate in any sport?
   _____ Yes: Explain _____ _____ No
5. Do you have any chronic conditions, disorders or diseases? Check if these are applicable …… _____No
   _____ Asthma _____ Bleeding Disorders _____ Diabetes _____ Epilepsy
   _____ Hepatitis _____ High Blood Pressure _____ Sickle Cell _____ Other _____
   _____ Mononucleosis – Year _____ _____ Kawasaki's disease

Please check where applicable is you have or have had any of the following:

	YES	NO		YES	NO
Head injury, concussion, or been unconscious	_____	_____	Eye injury or retinal detachment	_____	_____
If yes, how many times _____			Blurred vision or vision in one eye only	_____	_____
Headaches more than once a week	_____	_____	Wear glasses or contact lenses	_____	_____
Lack of feeling or numbness in anywhere	_____	_____	Hearing loss or impairment	_____	_____
Heat exhaustion or heat stroke	_____	_____	Tubes in ears or perforated ear drum	_____	_____
Difficulty running a half mile without stopping	_____	_____	False teeth, caps, or braces	_____	_____
Chest pain, dizziness or passing out	_____	_____	Nose bleeds for no reason	_____	_____
Coughing, wheezing, or gasping for breath			Bruising easily or taking a long time to		
With exercise or cold weather	_____	_____	stop bleeding when cut	_____	_____
Smoke cigarettes or chew tobacco	_____	_____	Diarrhea more than once a week	_____	_____
Heart problem, murmur or arrhythmia	_____	_____	Black or bloody bowel movements	_____	_____
Family member with heart attack under age 50	_____	_____	Kidney disease or dark brown urine	_____	_____
Loss or gain of more than 10 pounds in last yr.	_____	_____	Less than 2 kidneys or males 2 testicles	_____	_____
Special diet for medical reasons	_____	_____	Lumps in arm pit or groin	_____	_____
For female participants:			Rash or skin problems	_____	_____
Absent or irregular monthly periods	_____	_____	Neck, spine, or low back injury or pain	_____	_____
Disabling cramps with periods	_____	_____			
Have you ever been hospitalized for medical or surgical reasons? ……				_____	_____

REASON	YEAR	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please carefully list below and injury (nerve, muscle, bone, or joint) you have had which did not allow you to participate in regular activity for a week or more.

INJURED AREA (Knee, hamstring, neck, shin, etc.)	YEAR	SIDE	HOSPITAL
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

STUDENT AND PARENT OR GUARDIAN:
We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

_____ _____ _____ _____
Student Signature Date Parent or Guardian Signature Date