MEDICAL DEPARTMENT UTICA CITY SCHOOL DISTRICT

SPORTS CANDIDATES' QUESTIONNAIRE
(To be completed by Parent)

Grade____
School____________

## ATHLETIC HEALTH HISTORY

NAME________________________________________ Birth Date________________

Participation in athletics is voluntary and is not a required part of the regular physical education program.

## SPORTS ACTIVITIES

Identify any sports in which you do not wish your child to participate.________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

**THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER PHYSICAL.**

## HEALTH HISTORY TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Allergies/Hay Fever | ☐ | ☐ | Elevated Blood Pressure | ☐ | ☐ |
| Bee Sting Allergy | ☐ | ☐ | Headaches | ☐ | ☐ |
| Asthma | ☐ | ☐ | Head Injury/Concussion | ☐ | ☐ |
| Anemia | ☐ | ☐ | Heart Problem-Murmur-Chest Pains | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Nose Bleeds Frequent or Severe | ☐ | ☐ |
| Bladder/Kidney Problem or Injury | ☐ | ☐ | Ankle Injury | ☐ | ☐ |
| Convulsions/Seizures | ☐ | ☐ | Back Pain/Injury | ☐ | ☐ |
| Fainting Spells | ☐ | ☐ | Fracture-Dislocation Bones/Joints | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Knee Pain/Injury | ☐ | ☐ |
| Ear Problems/Hearing Loss | ☐ | ☐ | Neck Injury | ☐ | ☐ |
| Eye Problems/Vision Loss | ☐ | ☐ | Nose Fracture | ☐ | ☐ |
| Injury to the Spleen | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Joint Sprain/Ligament Tear/Muscle Pull | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Is there a current medical examination on file in the nurse's office? | ☐ | ☐ |
| Is your child assigned to the Adaptive Physical Education Program or has he/she been in an Adaptive Physical Education? | ☐ | ☐ |
| Has your child been unconscious or lost memory from a blow on the head? | ☐ | ☐ |

(Over)

*History Continued*

**Does your child have any of the following:**

| | Yes | No |
|---|---|---|
| One Eye or Severe Uncorrectable Loss of Vision in one or both eyes | ☐ | ☐ |
| Severe Hearing Loss in both ears | ☐ | ☐ |
| One Kidney | ☐ | ☐ |
| One Testicle | ☐ | ☐ |
| Has your child been ill for five (5) consecutive days? | ☐ | ☐ |

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital, either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? ☐ ☐

Is your child under medical care now? ☐ ☐

Has your child taken any medication in the past year? ☐ ☐

If so, why? ____________________

Is your child taking any medication now? ☐ ☐

If so, why? ____________________

Has your child ever fainted during excercise? ☐ ☐

If so, explain ____________________

Has there ever been sudden death in a family member under fifty (50) years of age? ☐ ☐

Do you have any worries about your child's health or other questions you would like to discuss with a doctor? ☐ ☐

Does your child have: Orthodontic Appliances? ☐ ☐

Capped Teeth? ☐ ☐

Wear contact lens for sports? ☐ ☐

Wear glasses for sports? ☐ ☐

Since your child's last physical examination has your child had any injury or medical illness? ☐ ☐

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

**PARENT SIGNATURE** ____________________ **DATE** ____________________

ADDRESS ____________________ TELEPHONE NUMBER ____________________

THIS FORM IS TO BE FILLED OUT COMPLETELY BEFORE THE STUDENT IS ALLOWED TO PRACTICE AND/OR COMPETE.