UTICA CITY SCHOOL DISTRICT
Medical Department
106 Memorial Parkway
Utica, NY 13501

STUDENT HEALTH HISTORY

ATHLETE'S NAME: _____ DOB_____GRADE_____ AGE_____ GENDER_____	**APPROVED FOR SPORTS BY SCHOOL NURSE** ☐ Y ☐ N NAME_____

Has your child in the past 12 months:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Life threatening allergies requiring Epi-Pen	☐	☐	
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Wear dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD CURRENTLY:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

Please explain any boxes checked. Add an additional paper if necessary: _____

_____

_____

_____

Please list any current medications your child is taking: _____

_____

_____

Parent Consent: 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 deemed necessary by designated school authorities.

Parent/Guardian Signature: _____ Date: _____

Parent print name: _____ Address _____

Home phone: _____ Cell Phone: _____

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EMERGENCY MEDICAL TREATMENT

In the event of an illness/injury, I give consent for emergency medical treatment of my child. This treatment must be deemed necessary by physician or other medical professional designated by the Utica City School District.

ATHLETE'S NAME:_____ SPORT_____

ATHLETE'S DATE OF BIRTH_____LAST PHYSICAL DATE_____

PARENT OR GUARDIAN'S NAME_____

HOME PHONE: _____ CELL PHONE_____

WORK PHONE_____

PHYSICIANS NAME_____ PHYSYCIAN'S PHONE_____

INSURANCE CARRIER_____ POLICY NUMBER_____

PREFERRED HOSPITAL_____

EMERGENCY CONTACT IF GUARDIAN CANNOT BE REACHED :

1) NAME_____ RELATIONSHIP_____

PHONE NUMBER_____

2) NAME_____ RELATIONSHIP_____

PHONE NUMBER_____

PARENT SIGNATURE:_____ DATE:_____