



Ilion Junior-Senior High School Athletic Health History

Student: _____

Grade: _____ Date entered 9th grade: / /

Age: _____ Birthdate: / /

Physical by School Physician Date: _____

Physical by Private Physician 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: _____

Please explain: _____

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE THE ATHLETE WILL BE ALLOWED TO PRACTICE

Has your child ever had: (Please check) Write date if indicated after last physical.

	Yes	No	Date		Yes	No	Date
Allergies/Hay Fever	___	___	_____	Head Injury/Concussion	___	___	_____
Bee Sting Allergy	___	___	_____	Heart Problem/ Murmur-Chest pains	___	___	_____
Asthma	___	___	_____	Ankle Pain/Injury	___	___	_____
Anemia	___	___	_____	Knee Pain/Injury	___	___	_____
Arthritis	___	___	_____	Back Pain/Injury	___	___	_____
Bladder/Kidney Problem or Injury	___	___	_____	Neck pain/Injury	___	___	_____
Convulsions/Seizure	___	___	_____	Fracture/Dislocation	___	___	_____
Diabetes	___	___	_____	Joint/Sprain/Ligament Pull	___	___	_____
Fainting Spells	___	___	_____	Muscle Tear	___	___	_____
Capped Teeth	___	___	_____	Nose Bleeds/Frequent or Severe	___	___	_____
Orthodontic Appliances	___	___	_____	Elevated Blood Pressure	___	___	_____
Ear Problems/Hearing Loss	___	___	_____	Rheumatic Fever	___	___	_____
Eye Problems/Vision Loss	___	___	_____	Wears Glasses for Sports	___	___	_____
Injury to Spleen	___	___	_____	Wears Contacts for Sports	___	___	_____
Stomach Ulcer	___	___	_____	Shatterproof lens/sport glass	___	___	_____
Headaches	___	___	_____				

Is there a current medical examination on file in the nurse's office? Yes _____ No _____

Has your child been unconscious or lost memory from a blow on the head? Yes _____ No _____

Does your child have any of the following:

One eye or Severe Uncorrectable Loss of vision in one or both eyes Yes _____ No _____
Severe hearing loss in both ears Yes _____ No _____
One Kidney Yes _____ No _____
One Testicle Yes _____ No _____
Has your child been ill for five (5) consecutive days? Yes _____ No _____
If so, explain _____

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 for x-rays, required an operation, caused your child to miss a game or practice: Yes _____ No _____

If so, explain _____

Is your child under medical care now? Yes _____ No _____
Has your child taken any medication in the past year? Yes _____ No _____
If so, why _____

Has your child ever fainted during exercise? Yes _____ No _____
If so, explain _____

Has there ever been sudden death in a family member under fifty (50) years of age? Yes _____ No _____
If so, explain _____

Do you have any worries about your child's health or other questions you would like to discuss with a doctor? Yes _____ No _____

I agree with the above answers and consent to the participation of my child in the interscholastic program of Ilion Central 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/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Date: _____