

**ELMSFORD UNION FREE SCHOOL DISTRICT
ALEXANDER HAMILTON HIGH SCHOOL**

ATHLETIC HEALTH HISTORY FORM

Athlete's Name: _____

Date of Birth: ____/____/____

Sports Activities

Please list any sports you **do not** wish your child to participate in.

**HEALTH HISTORY
TO BE COMPLETED BY PARENT OR GUARDIAN**

Has your child ever had: (please check)

| | Yes | No | | Yes | No |
|--------------------------|------------|-----------|-----------------------------------|------------|-----------|
| Allergies, Hay Fever | í | í | Elevated Blood Pressure | í | í |
| Bee Sting Allergy | í | í | Headaches | í | í |
| Asthma | í | í | Concussion/Head Injury | í | í |
| Anemia | í | í | Heart Problems/Murmur/Chest Pains | í | í |
| Bladder/Kidney Problems | í | í | Nose Bleeds/Frequent or Severe | í | í |
| Convulsions/Seizures | í | í | Ankle Injury | í | í |
| Diabetes | í | í | Fracture Dislocation | í í | |
| Ear Problem/Hearing Loss | í | í | Injury/Knee Pain | í í | |
| Eye Problems/Vision Loss | í | í | Neck Injury | í í | |
| Spleen Injury | í | í | Nose Fracture | í í | |
| Join Sprain | í | í | Rheumatic Fever | í í | |
| Fainting Spells | í | í | Stomach Ulcer | í í | |

| | | | |
|---|-----|------------|-----------|
| Is your child assigned to the Adaptive Physical Education Program, or has your child ever been in an Adaptive Physical Education Program. | í í | Yes | No |
|---|-----|------------|-----------|

| | | |
|---|---|---|
| Has your child been unconscious or lost memory from a blow to the head. | í | í |
|---|---|---|

All questions answered "Yes" must be explained on the back of this page.

Over >>>

Does your child have any of the following:

| | Yes | No |
|---|------------|-----------|
| One eye, or severe uncontrollable loss of vision in one or both eyes ----- | í | í |
| Severe hearing loss in both ears. ----- | í | í |
| One Kidney ----- | í | í |
| Has your child been ill for 5 (five) consecutive days in the last 12 months. ----- | í | í |
| 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, or a required operation. | í | í |
| Is your child under medical care now? ----- | í | í |
| Has your child taken any medication in the past year? ----- | í | í |
| If yes, why? _____ | | |
| Is your child taking medication now? ----- | í í | |
| If yes, why _____ | | |
| Has your child ever fainted during exercise? ----- | í | í |
| Has there ever been sudden cardiac death in a family member under fifty (50) years of age? | í | í |
| Does your child have: | | |
| Orthodontic appliances ----- | í | í |
| Capped teeth ----- | í | í |
| Wear contact lens for sports? ----- | í | í |
| Wear glasses for sports ----- | í | í |
| Since your child's last physical examination, has your child had an injury or medical illness | í | í |
| If you have answered yes to any of the questions on this side, or the other side of this form please explain why. | | |

I agree with the above answers, and consent to participation of my child in the interscholastic programs 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.

Signature of Parent or Guardian: _____ **Date :** ____ / ____ / ____