PORT JERVIS SCHOOL DISTRICT ATHLETIC HEALTH HISTORY

This form must be completed/signed by a parent/guardian and returned to the School Nurse at the time a sports physical is done.

Student Name:_____

Has your child ever had (please circle yes/no):

Allergies/hay fever	yes	no	Elevated blood pressure	yes	no
Bee sting allergy	yes	no	Headaches	yes	no
Asthma	yes	no	Head injury/concussion	yes	no
Anemia	yes	no	Heart Problems/murmur	yes	no
Arthritis	yes	no	Bone Injury/fracture/dislocation	yes	no
Nose Bleeds/frequent/severe	yes	no	Back or neck pain/injury	yes	no
Bladder/Kidney problem/injury	yes	no	Fainted during exercise/spells	yes	no
Seizures	yes	no	Stomach Ulcer	yes	no
Ear Problems/a Hearing Loss	yes	no	Nasal fracture	yes	no
Spleen Injury	yes	no	Rheumatic Fever	yes	no
Joint/ligament/muscle injury	yes	no	Eye problems/vision loss	yes	no
Is your child missing (circle if yes):			a kidney a testicle	an eye	
Is your child now or ever been assigned to Adaptive Physical Education?				yes	no
Does your child have/wear an orthodontic appliance?				yes	no
Does your child have any capped teeth?				yes	no
Does your child wear contact lenses or glasses?				yes	no

Has your child been sick for 5 consecutive days or more in the last year? Please explain:_____

Is your child currently being treated for a medical condition (asthma, diabetes, seizures): Please explain:_____

_____

Is your child currently taking any medication? If yes, please name the medication and why:_____

_____

The above information is correct and accurate. I consent to the participation of my child in _____, including practice sessions, games, events, as well as travel to and from all athletic events. I agree to emergency medical treatment as deemed necessary by the school designated authorities. I have read the insurance information form and rules for participation in the PJ Athletic Program.

PARENT/GUARDIAN SIGNATURE: _____ Date:_____

Parent signature is required above & on the opposite side of this form