MEDICAL HISTORY

Child's Name: _____ Grade:_____ Date: _____

Address: _____ City:_____ Zip Code: _____

Date of Birth: _____ Place of Birth (City and State) _____

Notify in case of an emergency: _____ **Telephone No.** _____

Cell Phone No. _____

Explain "Yes" Answers in the space provided on Page 2. Please circle Yes or No.

Have you ever been hospitalized?	Yes	No
Have you ever had surgery?	Yes	No
Are you presently taking any medications or pills (including inhalers)	Yes	No
Do you have any allergies to medication, insect bites, foods, etc.?	Yes	No
Have you ever passed out during or after exercise?	Yes	No
Have you ever felt dizzy during exercise?	Yes	No
Do you tire more quickly than your friends during exercise?	Yes	No
Have you ever had high blood pressure?	Yes	No
Have you ever been told you have or had a heart murmur?	Yes	No
Have you ever had racing of your heart or skipped heart beats?	Yes	No
Has anyone in your family died of heart problems or a sudden death before the age of 50?	Yes	No
Do you have any skin problems (**Please Circle:** itching, rashes, acne)?	Yes	No
Have you ever had a head injury (concussion)?	Yes	No
Have you ever been knocked out or unconscious?	Yes	No
Have you ever had a seizure or Epilepsy?	Yes	No
Have you ever had heat or muscle cramps?	Yes	No
Have you ever been dizzy or passed out in the heat?	Yes	No
Do you have trouble breathing or do you cough during exercise?	Yes	No
Do you have Asthma or Exercise-induced asthma?	Yes	No
Have you ever sprained, strained, dislocated, fractured or had repeated swelling or other injuries to any bones or joints?	Yes	No

Head ___ Shoulder ___ Thigh ___ Neck ___ Ankle ___ Chest ___

Back ___ Wrist ___ Knee ___ Hand ___ Hand ___ Foot ___

Hip ___ Elbow ___ Forearm ___ Shin/Calf ___

Have you ever had a bone infection? Yes No

Do you now or have you ever had:

Diabetes? Yes No

Problems with your eyes or vision (retina tear, corneal tear)? Yes No

Do you wear glasses or contact lenses? Yes No

Hearing loss? Yes No

Frequent ear infections? Yes No

Perforated ear drum? Yes No

Sinus infections? Yes No

Tendency to bleed or bruise easily? Yes No

Weight problem? Yes No

Hay fever? Yes No

Have you ever had any other medical problems (Mononucleosis, Lyme's Disease, etc.) Yes No

Are you presently under a physician's care? Yes No

Please explain in detail all your "Yes" answers:

_____

_____

_____

To the best of my knowledge, my answers to the above questions are true and correct.

Child's Name:(Please Print) _____ **Parent/Guardian Signature:** _____

Date Form Completed by Parent/Guardian: _____