ATHLETIC HEALTH HISTORY

Port Jefferson Middle School and Earl L. Vandermeulen High School
350 Old Post Road
Port Jefferson, NY 11777

STUDENT:____DOB: ______________

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:

____
____

THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER SCHOOL PHYSICAL.

THOSE STUDENTS HAVING THEIR PHYSICAL DONE BY THEIR PRIVATE PHYSICIAN – PLEASE HAVE YOUR DOCTOR SIGN THE BACK OF THIS FORM AFTER REVIEWING MEDICAL HISTORY.

HEALTH HISTORY - TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	o	o	Elevated Blood Pressure	o	o
Insect Sting Allergy	o	o	Headaches	o	o
Asthma	o	o	Head Injury/Concussion	o	o
Anemia	o	o	Heart Problem/Murmur-Chest pain	o	o
Arthritis	o	o	Nose Bleeds/Frequent or Severe	o	o
Bladder/Kidney Problem or Injury	o	o	Ankle Injury	o	o
Convulsions/Seizures	o	o	Back Pain/Injury	o	o
Fainting Spells	o	o	Fracture-Dislocation Bones/Joints	o	o
Diabetes	o	o	Knee Pain/Injury	o	o
Ear Problems/Hearing Loss	o	o	Neck Injury	o	o
Eye Problems/Vision Loss	o	o	Nose Fracture	o	o
Injury to the Spleen	o	o	Rheumatic Fever	o	o
Joint, Ligament, Muscle Injury	o	o	Stomach Ulcer	o	o

	YES	NO
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	o	o
Has your child been unconscious or lost memory due to a blow on the head?	o	o

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes……………………….	o	o
Severe hearing loss in both ears……………………………………………………………	o	o
One kidney………………………………………………………………………………….	o	o
One testicle…………………………………………………………………………………	o	o
Has your child been ill for five (5) consecutive days?…………………………………….	o	o

____
____

	YES	NO
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; required an operation; caused your child to miss a game or practice?__________________________	o	o

OVER →

History Continued **YES** **NO**

Is your child under medical care now?…………………………………………………. o o
Has your child taken any medication in the past year?……………………………………. o o
If so, why? ____
Is your child taking any medications now?……………………………………………….. o o
If so, why? ____
Has your child ever had chest pain or discomfort during EXERTION or REST o o
If yes, please describe:____
____
Has your child ever passed out or almost passed out during EXERTION or REST? o o
If yes, please describe:____
____
Has your child ever been short of breath or very fatigued with EXERCISE? o o
If yes, please desscribe____
____
Has your child ever been told they have a heart murmur? o o
If yes, please describe the pathology____
____
Has your child ever had high blood pressure? o o
If yes, please describe:____
Has anyone in your family died before age 50 due to heart disease? o o
If yes, please describe____
____
Do you know of any close relatives less than 50 years old that are disabled with heart o o
disease? If yes, please describe____

Do you know of any family members with the following heart diseases: Hypertrophic Cardiomyopathy, Dilated Cardiomyopathy, Long-qt Syndrome, Marfan Syndrome, Arrhythmogenic Right Ventricular Dysplasia, Anomalous Coronary Artery, Cathecholaminergic Polymorphic Ventricular Tachycardia (CPVT), Arrhythmias, Wolff-Parkinson-White Syndrome? o o
If yes, please describe____
____

Do you have any worries about your child's health or other questions you would like to discuss with a doctor?……………………………………………………………………. o o
Does your child have: orthodontic appliances?…………………………………………… o o
Capped teeth?……………………………………………………………………………….o o
Wear contact lenses for sports?……………………………………………………………. o o
Wear glasses for sports?…………………………………………………………………… o o
Since your child's last physical examination, has your child had any injury or illnesses?.. o o
____

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 the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE:______________________________**Date**:__________________

I have reviewed and discussed this questionnaire with the patient and their parent or guardian.

PHYSICIAN SIGNATURE:______________________________**Date**:__________________

PHYSICIAN STAMP HERE: