Sodus Central School
Sports Health History Form

Part A:
(To be completed by Parent/Guardian)
Student Name:_____ Age_____yrs.
Address:_____
Grade: 7 8 9 10 11 12 (circle one) Date of Birth ___/___/_____

Sport:_____ Level: Varsity JV Modified

HISTORY SINCE LAST PHYSICAL

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity above. However, it will require approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office and by the coach and will be kept confidential.

If the answer to any of the following questions is "Yes" please describe the condition or situation that prompted your answer.

			Explain
1. Any injuries requiring medical attention?	□ Yes	□ No	_____
2. Any illness lasting more than five (5) days?	□ Yes	□ No	_____
3. Taking medicine or under physician's care at this time?	□ Yes	□ No	_____
4. Any feeling of faintness, dizziness, fatigue or chest pain after exercise or exertion?	□ Yes	□ No	_____
5. Change in wearing glasses or contact lenses?	□ Yes	□ No	_____
6. Any surgical operation or fractures?	□ Yes	□ No	_____
7. Any treatment in a hospital or emergency room?	□ Yes	□ No	_____
8. Developed any allergies/skin rashes?	□ Yes	□ No	_____
9. Any chronic disease/special conditions?	□ Yes	□ No	_____

PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate. I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.
Signed:_____

Mother/Guardian_____ Home/Cell_____Work/Cell_____
Father/Guardian_____ Home/Cell_____Work/Cell_____
Health Insurance Company_____Plan #_____
Choice of Hospital_____Family Doctor_____
Emergency Contact _____ Phone:_____

Part B:
(To be completed by School Health Department)
Date of last Physical:____/____/_____
Health history reviewed and approved by Health Office Designee.
Signed:_____Date:____/____/_____

Health history reviewed and sent to school physician for approval (as needed).
Signed:_____Date____/____/___