Report of Medical History

To the Parent or Guardian:

This form is to be completed by the parent or guardian.

Student's Name _____ **Date of Birth** _____ **SS#** _____
Last First Middle

Address _____ **Parent's Name** _____

City _____ **Prov/State** _____ **Postal Code/Zip** _____ **Country** _____

Personal Physician _____ **Physician's Phone** _____

Questionnaire:

For each question, check the box for "Yes" or "No". Provide an explanation in the space provided for all questions with a "yes" response. Attach an additional sheet if necessary.

Yes	No	Has the student ever been hospitalized?	
Yes	No	Has the student ever had surgery?	
Yes	No	Is the student presently under a doctor's care?	
Yes	No	Is the student presently taking any medication?	
Yes	No	Does the student have any allergies?	
Yes	No	Has the student ever passed out during or after exercise?	
Yes	No	Has the student ever been dizzy during or after exercise?	
Yes	No	Has the student ever had chest pain during or after exercise?	
Yes	No	Has the student ever had high blood pressure?	
Yes	No	Has the student ever been diagnosed with a heart murmur?	
Yes	No	Has the student ever had racing of the heart or skipped heart beats?	
Yes	No	Has anyone in the student's family died of heart disease?	
Yes	No	Has the student ever had a head injury?	
Yes	No	Has the student ever been knocked out or been unconscious?	
Yes	No	Has the student ever had a seizure or epilepsy?	
Yes	No	Has the student ever had heat illness, heat cramps, or muscle cramps?	
Yes	No	Does the student have skin problems? (acne, itching, rashes)	
Yes	No	Does the student have trouble breathing?	
Yes	No	Does the student problems with vision?	
Yes	No	Does the student problems with blood sugar?	

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Yes No Has the student ever been treated for cancer or a tumor? _____

Yes No Has the student ever been treated a physical abnormality? _____

Yes No Has Ritilan or Cylert ever been prescribed for the student? _____

Yes No Have stimulants or antidepressants ever been prescribed for the student? _____

Yes No Has the student ever been treated for alcohol abuse? _____

Yes No Has the student ever been treated for substance abuse? _____

Yes No Has the student ever been sexually active? _____

Yes No Has the student ever been sexually or physically abused? _____

Yes No Has the student ever been treated for a sexually transmitted disease? _____

Yes No Has the student ever been treated for bulimia or anorexia nervosa? _____

Yes No Has the student required the services of a psychiatrist, psychologist or therapist? _____

Injury History:

Has the student sprained, strained, dislocated, fractured or broken any of the following. Also, indicate any areas of repeated swelling. Place a checkmark in each box that applies. If the student has sustained an injury, identify the type of injury in the space to the right Please give an explanation for each injury in the space provided below.

Head	_____	Neck	_____	Shoulder	_____	Upper Arm	_____
Elbow	_____	Forearm	_____	Wrist	_____	Hand	_____
Back	_____	Ribs	_____	Pelvis	_____	Hips	_____
Thigh	_____	Knee	_____	Shin/Calf	_____	Ankle/Foot	_____

_____

_____

Illness History:

Has the student had any of the diseases listed below. Place a checkmark in each box that applies and give the approximate date in the space provided.

Measles	_____	Mumps	_____	Rubella	_____	Chickenpox	_____
Hepatitis	_____	Malaria	_____	Tuberculosis	_____	Rheumatic Fever	_____
Scarlet Fever	_____	Polio	_____	Diphtheria	_____		

Tetanus Typhoid: What is the date of the student's last tetanus booster? _____ (Must be within the last ten years.)

I hereby state that, to the best of my knowledge, the above answers are correct.

Signature of Parent: _____ _____
Date