

PRE-PARTICIPATION FORM

Date of last Physical _____

Date of last Tetanus _____

CHILD'S NAME _____
 (LAST) (FIRST) (MI)

(STREET ADDRESS) (CITY) (STATE) (ZIP) (PHONE)

DATE OF BIRTH ____/____/____ AGE ____ GRADE COMPLETED (6/18) ____

Parent 1's Name _____ Parent 2's Name _____

Medical History

MUST BE COMPLETED BY PARENT ANSWER ALL QUESTIONS INCOMPLETE FORMS WILL BE RETURNED

HAS STUDENT EVER EXPERIENCED :	NO	YES	Dates ALL YES ANSWERS MUST BE EXPLAINED
Allergies			
Asthma /ReactiveAirway/ Any Breathing Problems			
Blood Disorders/Nose Bleeds			
Cancer			
Chicken Pox			
Diabetes			
Headaches/ Concussion/ Unconsciousness/Memory Loss/Head Blow/Black Outs			
Hearing Problems/Hearing Aid			
Heart Disease/Problems with exercise			
Hepatitis			
Hi/Lo Blood Pressure/Fainting			
Hospitalizations/Infections/ER Visits			
Kidney /Urinary Tract Problem			
Medication Reactions			
Menstrual Disorder			
Mononucleosis/Fatigue/Tiredness			
Muscular Disorder/Ligament/ Tendon Damage/Injury/Sprains			
Orthopedic Disorder/ Broken Bones			
Chest Pain/Racing Heart			
Scoliosis			
Seizure Disorder			
Strep Infections			
Surgery/Out patient Procedures/Tests			
Ulcer/Gastrointestinal Disorder			
Visual Problems/Glasses/Contact Lenses			
Other			

Does student take any medication on a regular basis ? ___N ___ Y

Name of Medication _____

 PARENT SIGNATURE

 DATE