

**MORIAH CENTRAL SCHOOL DISTRICT
HEALTH HISTORY**

(Sports Physicals are valid for 12 months, UNLESS an injury or prolonged illness has occurred. An additional medical exam and physician's clearance is required for continued sports participation. At the beginning of each season, a health history review for each athlete is required, unless the student received a full medical exam within 30 days of the start of the season.)

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TO BE COMPLETED BY PARENT

STUDENT NAME _____ **AGE** _____ **GRADE** _____ **LAST PHYSICAL** _____

1. Presently taking any Medication(s) _____ Insulin _____ Inhalers _____ Epipen _____
2. Please list Medication(s) _____
3. Are there any side effects that we should be aware of? ___ Yes ___ No.
4. If Yes, please describe _____
5. Allergies and Symptoms to: Medication(s) _____ Foods _____
6. Insect/Bee Allergy / Reaction _____
7. Any Surgeries (Dates) _____
8. Stayed Overnight in the Hospital (Dates) _____
9. Had a prolonged illness within the past year (5 days or greater) _____
10. Under Physician's care for a current health issue? Asthma _____ Diabetes _____ Depression _____
11. Had loss of memory or consciousness from a blow to the head? _____
12. In the past two years had a serious sprain _____ or fractured bone(s) _____
13. During exercise, begin to cough _____ wheeze _____ shortness of breath _____
14. During exercise, felt dizzy _____ fainted _____ had chest pain _____
15. Family History of heart disease _____ stroke _____ or heart attack _____ before 50 years old.
16. Been diagnosed with high blood pressure _____ heart murmur _____ or heart problems _____
17. Have frequent (more than twice/week) headaches _____ stomachaches _____ or other complaints _____
18. Have difficulty with sleeping _____ or eating _____
19. Wears Glasses _____ Contacts _____
20. Any restrictions to Physical Education/Sports _____
21. Have any concerns/questions _____

Please indicate if your child has had any of the following, by entering the date:

Asthma _____
Allergies _____
Anemia _____
Arthritis _____
BeeStingReaction _____
Blood Disorder _____
Blood Transfusions _____
Braces/Capped Teeth _____
Chicken Pox _____
Diabetes _____
Ear conditions _____
Ear Tubes _____
Epilepsy _____

Frequent Colds _____
German measles _____
Head Injuries/Concussions _____
Heart Disorder _____
Hepatitis _____
History of PKU _____
Kidney Problems _____
Migraines _____
Measles _____
Mumps _____
Pneumonia _____
Rheumatic Fever _____
Scarlet Fever _____

Scoliosis _____
Serious Injuries _____
Skin Conditions _____
Sore Throat _____
Strep Throat _____
Surgeries _____
Tonsillitis _____
Tuberculosis _____
Vision Difficulties _____
Whooping Cough _____

I certify, to the best of my knowledge, that the above information is correct.

Parent/Guardian Signature

Date

