

Catholic Central High School

“Cherishing the

Past – Embracing the Future”

625 Seventh Avenue
 Troy, New York 12182-2595
 (518) 235-7100 – Fax 237-1796
www.cchstroy.org

Physical will be conducted on:

Grade _____

Date _____

Time _____

ATHLETIC HEALTH HISTORY

SCHOOL NAME: CATHOLIC CENTRAL HIGH SCHOOL

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 PHYSICAL. THE APPOINTMENT DATE FOR THE PHYSICAL EXAMINATION IS IN THE UPPER LEFT HAND CORNER.

HEALTH HISTORY TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever			Elevated Blood Pressure		
Bee Sting Allergy			Headaches		
Asthma			Head Injury/Concussion		
Anemia			Heart Problem/Murmur-Chest Pain		
Arthritis			Nose Bleeds/Frequent or Severe		
Bladder/Kidney Problem or Injury			Ankle Injury		
Convulsions/Seizures			Back Pain/Injury		
Fainting Spells			Fracture-Dislocation Bones/Joints		
Diabetes			Knee Pain/Injury		
Ear Problems/ Hearing Loss			Neck Injury		
Eye Problems/Vision Loss			Nose Fracture		
Injury to the Spleen			Rheumatic Fever		
Joint Sprain/Ligament Tear/Muscle Pull			Stomach Ulcer		
				YES	NO
Is there a current medical examination on file in the nurse’s office?					
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the					

Adaptive Physical Education?		
Has your child been unconscious or lost memory from a blow on the head?		

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes		
Severe hearing loss in both ears		
One kidney		
One testicle		
Has your child been ill for five (5) consecutive days? _____ _____		
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? _____ _____		
Is your child under medical care now?		
Has your child taken any medication in the past year? <input type="checkbox"/> If so, why? _____ _____		
Is your child taking any medications now? <input type="checkbox"/> If so, why? _____ _____		
Has your child ever fainted during exercise If so, explain. _____		
Has there ever been sudden death in a family member under fifty (50) years of age? _____		
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?		
Does your child have: orthodontic appliances?		
Capped teeth?		
Wear contact lenses for sports?		
Wear glasses for sports?		
Since your child's last physical examination, has your child had any injury or illness? _____		

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/GUARDIAN

SIGNATURE: _____ **Date:** _____