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Name _____ DOB ___/___/___ Age ___ yrs ___ mos

Male/Female Height _____ Weight _____ BP ___/___ Pulse _____ Vision _____ Hearing _____

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Physical Date ___/___/___ Immunizations: Reviewed _____ and Attached _____

Physically Fit and Able to Play Sports: YES / NO / Restrictions are _____

HEALTH HISTORY [Please check all that apply]

____ Drug allergy [specify] _____ Reaction _____ Tx _____

____ Food allergy _____ Reaction _____ Tx _____

____ Environmental _____ Reaction _____ Tx _____

____ Asthma [type & med] _____ Well controlled - YES/NO

____ ADD/ADHD [med] _____ Well controlled - YES/NO

____ Diabetes [type, age of onset, med] _____ Well controlled - YES/NO

____ Seizure disorder [type & med] _____ Well controlled - YES/NO

____ Bleeding issue [type & med] _____ Well controlled - YES/NO

____ Heart condition [type & med] _____ Limitations _____

____ Surgery [type] _____ Date ___/___/___ Limitations _____

____ Injuries [fx, dislocations, etc; specify] _____ Date ___/___/___

____ Concussion Date ___/___/___ How occurred _____
LOC: YES/NO – Duration ___ sec ___ min ___ hr/s Seizure activity: YES/NO – Duration ___ sec ___ min
Side effects _____

____ Migraines [type & med] _____ Well controlled – YES/NO

____ Heat exhaustion/Heat stroke Date ___/___/___ Severity _____

____ Glasses/contacts [specify which & need for] _____

____ Braces [oral, arm, leg, back, neck & reason for] _____

____ **OTHER** _____ (additional info continued to back of page: yes / no)

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Medical Provider's Signature _____ **Date** ___/___/___
AND OFFICE STAMP