

SPORTS HEALTH UPDATE

Student's Name _____ Grade _____

Sport _____ Year _____

Parent/Guardian's Name _____

Home Phone # _____ Cell Phone # _____

Alternate Emergency Contact _____ Phone # _____

Physician's Name _____ Phone # _____

Student Allergies (bees, seasonal or medication) _____

Part A – History Since Last Health Appraisal:

If the answer to any of the following questions is "YES," please describe in Part B the condition or situation that prompted your answer.

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| 1. Any injuries requiring medical attention? | Yes | No |
| 2. Any illness lasting more than five (5) days? | Yes | No |
| 3. Taking medicine or under a physician's care at this time? | Yes | No |
| 4. Change in wearing contacts or glasses? | Yes | No |
| 5. Any chronic disease? | Yes | No |
| 6. Do you want to weigh more or less than you do now? | Yes | No |
| 7. Do you need to gain/lose weight to meet requirements for your sport? | Yes | No |
| 8. Have you ever had a seizure? | Yes | No |
| 9. Any feeling of faintness, dizziness, or fatigue after exercise? | Yes | No |
| 10. Have you ever passed out during or after exercise? | Yes | No |
| 11. Have you ever had racing of your heart or skipped heartbeats? | Yes | No |
| 12. Have you ever become ill from exercising in the heat? | Yes | No |
| 13. Do you cough, wheeze or have trouble breathing during or after exercise? | Yes | No |
| 14. Have you ever had a head injury or concussion? | Yes | No |
| 15. Have you ever been knocked out or become unconscious? | Yes | No |
| 16. Any surgeries or fractures? | Yes | No |
| 17. Any treatment in a hospital or emergency room? | Yes | No |
| 18. Is there any history of sudden death in the family? | Yes | No |
| 19. Has student or family members had heart problems? | Yes | No |

