CHATHAM HIGH SCHOOL
ATHLETIC HEALTH HISTORY

Athlete's name ______________________________

Sport ________________ Grade ____________

Does your child have (please indicate yes or no)

1. Severe insect sting or allergy? ________
   Medication in school for allergy? ________

2. Seizure disorder ________
   Medication in school for seizure? ________

3. Asthma ? ________
   Medication in school for asthma? ________

4. Any other chronic disease or condition? ________

5. Only one kidney or testicle? ________

6. Uncorrectable severe vision loss in one eye or both eyes? ________

7. Hearing loss in one ear or both ears? ________

8. Heart problem or murmur? ________
   Evaluated by a cardiologist? ________

9. History of concussion, loss of consciousness or memory loss from a head injury? ________

10. Sudden death (not accidental) in a family member under 50? ________

11. Had any injuries requiring medical attention within the past year? ________
    Any current restrictions due to injuries? ________

12. Had any surgical procedures within the last year? ________

13. Currently under a physician's care or taking any medications? ________

14. Wear contact lenses or glasses________ dental appliances________

Please explain any yes answers

____

____

____

____

____