

# ATHLETE'S MEDICAL INFORMATION

Athlete's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent's or Guardian's Name(s): \_\_\_\_\_

## Medical History

Complete the following:

Date

For each "yes" response provide additional information at the end of this section:

Last Tetanus Shot \_\_\_\_\_

Last Dental Exam \_\_\_\_\_

Last Eye Exam \_\_\_\_\_

Circle One

Does your child have a history of any of the following?

Is your child taking any medication?

Yes      No

General Conditions

Circle  
Yes or No

Circle one for  
any yes answer

Describe medication, amount, reason.

Fainting Spells or  
Dizziness

Yes      No

Past      Present

Does your child have allergic reactions to medications, bee stings, food, etc>? Describe agents and reactions

Yes      No

Headaches

Yes      No

Past      Present

Convulsions/Epilepsy

Yes      No

Past      Present

Does your child wear any appliances? Glasses, contact lenses, hearing aids, braces, etc.? Describe appliance

Yes      No

Asthma

Yes      No

Past      Present

High Blood Pressure

Yes      No

Past      Present

Has your child had any surgical operations?

Kidney Problems

Yes      No

Past      Present

Indicate site, reason for surgery. Level of success.

Yes      No

Intestinal Disorder

Yes      No

Past      Present

Has a physician placed any restrictions on your child's activities? Describe restriction.

Yes      No

Hernia

Yes      No

Past      Present

Diabetes

Yes      No

Past      Present

Has your child ever lost consciousness or had a concussion?

Yes      No

Heart Disease

Yes      No

Past      Present

Skin Disorder

Yes      No

Past      Present

Has your child experienced fainting or dizziness while exercising?

Yes      No

Allergies

Yes      No

Past      Present

Does your child have any medical or emotional problems that may require special attention of a sports coach? Explain.

Yes      No

Specify: \_\_\_\_\_

Please explain below any "Yes" responses or any other concerns that have implications for coaching your child. Also describe any special first aid requirements, if appropriate. An additional sheet may be attached if necessary.

List any Serious/Significant illness not included Above: \_\_\_\_\_

Injuries

Circle  
Yes or No

Circle one for  
any yes answer

Feet

Yes      No

Past      Present

Ankles

Yes      No

Past      Present

Legs

Yes      No

Past      Present

Hips

Yes      No

Past      Present

Back

Yes      No

Past      Present

Abdomen

Yes      No

Past      Present

Chest

Yes      No

Past      Present

Neck

Yes      No

Past      Present

Hands

Yes      No

Past      Present

Wrists

Yes      No

Past      Present

Arms

Yes      No

Past      Present

Shoulders

Yes      No

Past      Present

Head

Yes      No

Past      Present

Joint Dislocations or  
Separations

Yes      No

Past      Present

List Any Serious/Significant Injury Not Included Above: \_\_\_\_\_