

SANGER UNIFIED ATHLETIC MEDICAL INFORMATION

Student Name _____

Birth date _____

Sport _____

MEDICAL HISTORY	YES	NO
Have you been advised by a physician during the past 3 years to restrict activity?		
Are you under a physician's care now?		
Are you on any medication at the present time? Is yes, name of medication:		
Do you wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Dentures <input type="checkbox"/> Braces <input type="checkbox"/> Bridgework		
Date of last visit to dentist:		
Have you ever had a surgical operation?		
Have you ever been confined to a hospital?		
Have you had any illness or infection lasting more than a week?		
Have you ever fainted? If yes, how many times?		
Do you have frequent headaches?		
Have you ever had convulsions? If yes, how many times?		
Have you ever become weak or ill when exposed to high temperatures?		
Do you have loss or seriously impaired function of any paired organ? <input type="checkbox"/> eyes <input type="checkbox"/> lungs <input type="checkbox"/> kidneys		
Do you have or have you ever had: Asthma/hay fever		
Allergies, to what?		
Diabetes		
Heart Disease (rheumatic fever, high blood pressure, murmurs)		
Epilepsy		
Abnormal bleeding tendencies		
Kidney Disease		
Tuberculosis		
Stomach/Intestinal trouble		
Arthritis		
Have you ever been knocked unconscious? How many times?		
Were you evaluated by a doctor?		
Were you hospitalized?		
Have you ever had <input type="checkbox"/> Back pain <input type="checkbox"/> Shoulder problems <input type="checkbox"/> ankle sprain <input type="checkbox"/> knee trouble <input type="checkbox"/> Other:		

	5 th	6 th	7 th	8 th
DATE				
Pulse				
Blood Press				
Eye –Ear				
Nose-Throat				
Heart				
Lungs				
Neck				
Abdomen				
Back				
Knees				
Extremities				
Doctor Signature				

COMMENTS
