



MONTEBELLO UNIFIED SCHOOL DISTRICT

ATHLETIC HEALTH HISTORY FORM

Sport: _____

Birthdate: _____

To be completed, reviewed and signed by ***both*** parent/guardian and examining physician.

_____	_____	_____
Student Name	Grade	School

Please answer *ALL* questions by circling *YES* or *NO*.

- | | | |
|---|-----|----|
| 1. Has had an injury of a muscle, bone, joint, ligament, or tendon?
Was medical attention required? | Yes | No |
| 2. Has suffered a concussion? If yes, how many times? _____ | Yes | No |
| 3. Has fainted? If yes, how many times? _____ | Yes | No |
| 4. Has had illness lasting more than a week? | Yes | No |
| 5. Is under a physician's care at this time? Date: _____ | Yes | No |
| 6. Is taking any medication at this time? If yes, please list medication.
_____ | Yes | No |
| 7. Wears prescription glasses? | Yes | No |
| 8. Wears contact lenses? | Yes | No |
| 9. Has been hospitalized for injury or illness? If yes, please explain.
_____ | Yes | No |
| 10. Has been medically treated for emotional/mental illness concerns? | Yes | No |
| 11. Has been medically diagnosed for asthma? List prescribed inhaler
name: _____ | Yes | No |
| 12. Has had heart or lung problems requiring physicians care? | Yes | No |
| 13. Do you know of any reason why this student should not participate in any
Sport? If Yes, please explain: _____
_____ | Yes | No |

Signature: _____
(Examining Physician)

Date: _____

Signature: _____
(Parent/Guardian)

Date: _____

DOCTOR'S NAME STAMP: _____