BLIND BROOK HIGH/MIDDLE SCHOOL
HEALTH HISTORY REVIEW
(To be completed by parent or guardian)

Name _____Date of Birth_____
Grade _____Sport _____Home Telephone #_____
Home Address _____
Emergency Contact and Telephone #_____
Physician's Name_____Telephone #_____

Prior to the first practice of each season, a health history review for each student/athlete must be completed and returned to the Athletic Office. THIS IS IN ADDITION TO THE YEARLY SPORTS PHYSICAL - NOT IN PLACE OF THE SPORTS PHYSICAL.

SINCE THE PREVIOUS SCHOOL YEAR OR SINCE LAST QUESTIONNAIRE COMPLETED HAS STUDENT HAD?

_____ Any known medical condition
_____ Allergies
_____ Takes daily or frequent medication
_____ Emergency room care
_____ Heart disease or murmur/Irregular heart beat
_____ High blood pressure
_____ Asthma or lung disease
_____ Difficulty breathing
_____ Severe or recurrent chest pain
_____ Bleeding tendency or blood disease
_____ Serious head injury
_____ Loss of consciousness, fainting, or loss of memory
_____ Convulsions or seizures
_____ Recurrent headaches or migraines
_____ Wears glasses/contact lenses
_____ Hearing impairment
_____ History of diabetes
_____ Kidney disease
_____ Broken bones or joint disease
_____ Consulted with physician in past six months (other than normal checkup)
_____ Do you know any reason why this individual should not participate in sports

Please explain any "yes" answers to above questions: (include month & year)

I hereby certify that the above medical information is accurate and current. In case of accident or serious illness, I request the school contact me. If not able to reach me, I hereby authorize the school to call the physician indicated above and follow instructions given. If unable to contact physician, the school may make whatever arrangements necessary.

_____Date_____
Signature Required of Parent/Guardian