

ATHLETIC DEPARTMENT - MWCS

MEDICAL HEALTH HISTORY UPDATE FORM

Athletes Name: _____ Date of Birth: _____

Athletic Activity: _____ Grade Level: _____

<u>Item</u>	<u>History since last medical exam</u>	
	<u>Yes</u>	<u>No</u>
Any injuries requiring medical attention?	_____	_____
Any illness lasting more than five (5) days?	_____	_____
Taking any medicine or under physician's care at this time?	_____	_____
Any feeling of faintness, dizziness, or fatigue after heavy exertion?	_____	_____
Wears glasses or contact lenses?	_____	_____
A surgical operation or fracture?	_____	_____
Treated in a hospital or emergency room?	_____	_____
Any reason why this person can not participate in any sport?	_____	_____
Any known allergies?	_____	_____
Any chronic disease?	_____	_____
If yes to any of the above, describe:	_____	

PERMISSION

We understand clearly that the questions are asked in order to decide if this student is in a proper condition to participate in the athletic activity named at the top of this form. The answers are correct as of the date this form is signed. All answers will be kept confidentially in his/her record in the school health office.

Signature of Parent/Guardian	Date	Signature of Student	Date
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NOTE: "Yes" answers to any of these questions do not mean automatic disqualification, from the athletic activity indicated. They will require review and evaluation by the school physician.



FOR OFFICE USE

Date of last tetanus booster (within 10 years): _____

Date of Last Medical Exam: _____ Physician: _____

Were any defects noted in last exam or past school health record? Yes No

If yes, describe: _____

DISPOSITION:

Approved Referred Date: _____ R.N.

Approved

Not Approved

Date: _____ M.D.

Remarks: _____
