SOMERS CENTRAL SCHOOL DISTRICT / P.O. BOX 640, LINCOLNDALE, NY 10541
ATHLETIC DEPARTMENT (914) 248-7315 / SHS HEALTH OFFICE FAX (914)277-2451

SPORTS CANDIDATE HEALTH HISTORY

Athlete's Name: _____School: _____Date of Birth___/____/____Grade_____

Has your child ever had: (please check)

	Yes	Date	No		Yes	Date	No
Allergies (Please Specify):				Headaches / Migraines			
				Head Injury / Concussion #			
Asthma				Nose Bleeds Frequent / Severe			
Anemia (including Sickle Cell)				Heart Problems: Murmur-Chest Pains			
Arthritis				Elevated Blood Pressure			
Bladder/Kidney Problem				Diabetes I / II			
Convulsions / Seizures				Injury to spleen / Mononucleosis			
Ear Problems / Hearing Loss				Fainting Spells / Heat Exhaustion			
Eye Problems / Vision Loss							
Is your child assigned to the Adaptive Physical Education Program, or has he/she ever been in an Adaptive Physical Education Program?							

If you answered yes to any of the above please explain in details, you may use the back of this form if necessary _____

_____

Describe any major muscular-skeletal injury or problem that occurred in the last 3 years: _____

_____

Does your child have any of the following? (Please circle)

Has your child ever had a condition which required hospitalization / surgery? YES NO
If Yes, Explain: _____

Does your child have a current medical condition which is being monitored by a physician? YES NO
If Yes, Explain: _____

Is your child taking any medication now? YES NO
If Yes, Explain: _____

Has there ever been a sudden death in a family member under 50 years of age? YES NO
If Yes, Explain: _____

Do you have any worries about your child's health or other questions you would like to discuss with a Doctor? YES NO

Does your child have orthodontic appliances / capped teeth? YES NO

Does your child wear contact lenses / glasses for sports? YES NO

Since your child's last physical examination, has he/she had any injury or medical illness? YES NO
If Yes, Explain: _____

PLEASE CIRCLE ONLY ONE SPORT PER SEASON

*** A NEW HEALTH HISTORY FORM WILL BE NEEDED 30 DAYS PRIOR TO THE START OF EACH SEASON**

FALL-GIRLS	FALL-BOYS	WINTER-GIRLS	WINTER-BOYS	SPRING-GIRLS	SPRING-BOYS
Field Hockey	Football	Skiing	Skiing	Softball	Baseball
Soccer	Soccer	Basketball	Basketball	Track & Field	Track & Field
Cross Country	Cross Country	Gymnastics	Gymnastics	Lacrosse	Lacrosse
Volleyball		Cheerleading	Ice Hockey	Golf	Golf
Tennis		Track	Track		Tennis
Cheerleading			Swimming		
Swimming			Wrestling		

*** PLEASE NOTE: MEDICAL CLEARANCE MAY BE REQUIRED FOR NEW OR EXISITING CONDITIONS**

Inherent in athletic participation is the possibility of minor injury, and in the extreme, severe injury and even death. It is understood that Somers School District will provide proper equipment and training, as well as safe facilities, in order to minimize these risks. By my signature below, I agree to let the coach, trainer and/or administration administer proper first aid, contact emergency medical services if deemed necessary, and to contact me at the earliest opportunity. ***I have reviewed the NYPHSAAS Student/Parent Information Sheet regarding concussions at:**

http://www.nysphsaa.org/portals/0/pdf/safety/StudentParentConcussionInformation.pdf

Parents Signature: _____ Parents Phone #: _____ Date: _____/_____/_____

Rev 10/13