HICKSVILLE PUBLIC SCHOOLS HEALTH SERVICES

UPDATED SPORTS CANDIDATE HEALTH HISTORY FORM

PLEASE NOTE:

This form is only for the time period *SINCE YOUR LAST PHYSICAL:*

NAME_____

SEX: M F GRADE_____**SPORT**_____

PLEASE CIRCLE ONE

Since your last physical, have you/do you.....

1. Had any fractures, dislocations, severe sprains or serious injuries? YES NO
2. Been hospitalized or treated in the Emergency Room? YES NO
3. Had surgery? YES NO
4. Have any allergies and /or Asthma newly diagnosed? YES NO
5. Take any new medication? YES NO
6. Experienced any type of head injury or concussion? YES NO
7. Had any illness lasting more than 5 days? YES NO
8. Had any feeling of faintness, dizziness, or fatigue after heavy exertion? YES NO
9. Had any newly diagnosed serious illness? YES NO
10. Have a newly diagnosed heart murmur, high blood pressure, extra Heartbeat or any other heart abnormality? YES NO

If yes, please explain_____

To the best of my knowledge, the above information is correct:

PARENT/GUARDIEN SIGNATURE_____

Date_____

FOR SCHOOL USE ONLY- TO BE COMPLETED BY THE SCHOOL NURSE

DATE OF LAST PHYSICAL EXAM_____APPROVED_____

HEALTH RECORD REVIEWED_____

SIGNATURE OF SCHOOL NURSE_____

DATE_____