Medical History Form

Player Name ____ **Date** ________________

Birth date ________________________

If the answer to any of the following question is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following, please circle:

Head Injury (concussion, skull fracture)	**Yes**	**No**
Fainting spells	**Yes**	**No**
Convulsions/epilepsy	**Yes**	**No**
Neck or back injury	**Yes**	**No**
Asthma	**Yes**	**No**
High blood pressure	**Yes**	**No**
Kidney problems	**Yes**	**No**
Hernia	**Yes**	**No**
Diabetes	**Yes**	**No**
Heart murmur	**Yes**	**No**
Allergies	**Yes**	**No**
Specify: ____		
Injuries to:		
Shoulder	**Yes**	**No**
Knee	**Yes**	**No**
Ankle	**Yes**	**No**
Fingers	**Yes**	**No**
Arm	**Yes**	**No**
Other: ____	**Yes**	**No**
Impaired vision	**Yes**	**No**
Impaired hearing	**Yes**	**No**
Other: ____		

Have you had a recent tetanus booster? ___________ If so, when? ____________________________

Are you currently taking any medications? _________ What? Why?_______________________________

____

Please explain any restrictions the doctor has placed on your activity? ____________________________

____

Any other information that would be medically helpful?____

____

Parent/Guardian Signature ____________________________________ **Date**__________________

Team Reps: Please give original Medical History Form to the coach and keep a copy for your records.