

Medical History Form

Player's Name: _____
(Last) (First)

This form will constitute a medical history for our information. A complete physical exam by your family physician is advised if you feel it is necessary. **Please circle** the appropriate answer for the following questions.

1. Has your child ever shown any indication toward: **If answered "Yes" please explain.**

Yes No Being a diabetic? _____

Yes No Any type of seizures? _____

Yes No Any chronic disease or health problem? _____

Yes No Liver, spleen or kidney problems? _____

Yes No Heart or circulatory problems? _____

Yes No Respiratory problems? _____

Yes No Allergies? _____

Yes No Vision or hearing problems? _____

Yes No Hernia or genitalia problems? _____

Yes No Orthopedic (bone-joint-skeletal) problems? _____

Yes No Hemophilia, anemia or blood disorder? _____

2. Yes No Is your child presently under a physician's care for a medical problem?
Explain _____

3. Yes No Is your child presently taking any medications? Please list _____

AdditionalComments: _____

Parent or Guardian Signature: _____ Date _____