



Athletic Competition Health Form 2016-17

St. Ignatius Martyr Catholic School



To be completed by Parent				To be completed by Physician								
Student Name:				Physician's Name:			Phone:					
Age:		Grade:		Physician's Address:								
Date of Birth:		Gender:										
HEALTH HISTORY					Vitals		Satisfactory:		Vision: R _____ L _____		Recommended Follow-up	
Answer Yes or No ONLY			Yes	No			Yes	No	Hearing: 25 dB 1K 2K 4K			
					Ht:				Right: _____			
Chronic Illness					Wt:				Left: _____			
Hospitalization					BP:							
Surgery other than tonsils					General							
Injuries treated by physician												
Current medications												
Organs missing												
Heat exhaustion/stroke												
Dizziness, fainting, convulsions and/or headaches					Head							
Knocked unconscious												
Concussion												
Wear glasses/contacts					Eyes							
Hearing defects					Ears							
Dental appliances bridge/braces/plate					Dental							
Cough/pain					Chest							
Problems with blood pressure, heart or murmurs					Heart							
Problems with liver, spleen, or kidney					Abdomen							
Hernia					Genitalia							
Recurrent skin disease					Skin							
Bone/joint injury					Extremities							
Sprain/dislocation					Back/Neck							
Injury that caused a missed practice/event					Scoliosis Screening:							
Allergic to any medications? Name:					Allergy							
Tetanus booster in the last 10 years on Immunization Record?					Summary of comments:							
Parent/Guardian Signature:				Sports Participation: Yes No								
				notes:								
I certify that the above information is current and correct to the best of my knowledge:				Date		Physician Signature:			Date:			
						Physician Printed Name:						

Return to St. Ignatius Martyr Catholic School, 120 W. Oltorf Street, Austin, TX 78704