



Athletic Competition Health Form

School Year _____
 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	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:			Physician Signature:		Date:		
			Physician Printed Name:				

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