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 Answer **Yes** or **No** ONLY	Yes	No	Vitals Ht:	Satisfactory: Yes	No	**Vision:** R_____ L_____ **Hearing**: 25 dB 1K 2K 4K Right: ____ ____ ____ Left: ____ ____ ____	Recommended Follow-up
Chronic Illness			Wt:				
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 Sprain/dislocation Injury that caused a missed practice/event			Extremities Back/Neck				
			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