Health Record

Athlete's Name_____

Chronic or recurrent illness (diabetes, asthma, etc) Y / N
Illness lasting more than 1 week Y / N
Please list:_____
Problem with blood pressure or heart Y / N
Seizures, dizziness, fainting, convulsions, frequent headaches Y / N
Ever had concussion or knocked out Y / N
Wear eyeglasses or contact lenses Y / N
Allergic to any medication Y / N
Allergic to any foods Y / N
Please list:_____
Any allergies Y / N
Please list:_____
History of collapsed lung, tuberculosis, enlarged spleen, or liver Y / N
Have you had your pre season physical Y / N
Last tetanus shot:_____
Injuries in the past:_____

Athlete's signature:_____

Parent Guardian Signature:_____