CHEEKTOWAGA CENTRAL SCHOOL DISTRICT
REGISTRATION AND ATHLETIC HEALTH HISTORY

Name _____ Birthdate _____

Grade _____ Homeroom Teacher _____

Sports Activity _____ Coach _____

LEVEL (check) Varsity _____ JV _____ Modified _____

PLEASE CHECK IF YOU WILL HAVE YOUR PHYSICAL
EXAMINATION BY YOUR PRIVATE PHYSICIAN _____

HEALTH HISTORY (BOTH SIDES) TO BE COMPLETED BY PARENT

Has your child ever had: (please check all applicable, if yes please indicate month and year)

	Yes	No		Yes	No
Allergies/Hay Fever	____	____	Elevated Blood Pressure	____	____
Bee Sting Allergy	____	____	Headaches	____	____
Asthma	____	____	Head Injury/Concussion	____	____
Anemia	____	____	Heart Problem/Murmur-Chest Pains	____	____
Arthritis	____	____	Nose Bleed/Frequent or Severe	____	____
Bladder/Kidney/Problem or Injury	____	____	Ankle Injury	____	____
Convulsions/Seizures	____	____	Back Pain/Injury	____	____
Fainting Spells	____	____	Fracture-Dislocation Bones/Joints	____	____
Diabetes	____	____	Knee Pain/Injury	____	____
Ear Problems/Hearing Loss	____	____	Neck Injury	____	____
Eye Problems/Visions Loss	____	____	Nose Fracture	____	____
Injury to the Spleen	____	____	Rheumatic Fever	____	____
Joint Sprain/ Ligament Tear/Muscle Pull	____	____	Stomach Ulcer	____	____

Does your child have any of the following:

	Yes	No
One Eye or Severe Uncorrectable Loss of Vision in one or both eyes	____	____
Severe Hearing Loss in both ears	____	____
One Kidney	____	____
One Testicle	____	____
Has your child been ill for five (5) consecutive days?	____	____

If yes, explain _____

_____

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital, either as a patient Overnight or in the emergency room of for x-rays; required an operation; caused your child to miss a game or Practice? ____ ____

If yes, give date _____

_____

Is your child under medical care now? ____ ____

Has your child taken any medication in the past year? If yes, why? ____ ____

_____

_____

Is your child taking any medication now? If yes, why? ____ ____

_____

_____

Has your child ever fainted during exercise? If yes, explain. ____ ____

_____

_____

Has there ever been sudden death in a family member under fifty (50) years of age? ____ ____

Do you have any worries about your child's health or other questions you would like to discuss with a doctor? ____ ____

Does your child have:			
	Orthodontic Appliances	____	____
	Capped Teeth	____	____
	Wear Contact Lens for sports	____	____
	Wear Glasses for sports	____	____

Since your child's last physical examination has your child had any injury or medical illness? ____ ____

I agree with the above answers and consent to the participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent Signature _____ *Date*_____