HNHS
MEDICAL HISTORY QUESTIONNAIRE

Name:_____
(last) (first) (M.I.)
Date of Birth:_____ Phone #:_____
Address:_____
_____
Parent/Guardian(s):_____
Address (if different than above):_____
Family Physician:_____
Phone:_____
Emergency Contact:_____
Phone:_____
Insurance Carrier:_____ Insured's Name:_____
Address:_____ Policy No.:_____

Please circle the correct answer. All information will remain confidential.

YES NO 1. Has this athlete ever had hospitalization, surgery, injury or serious medical illness?

YES NO 2. Is this athlete now under the care of a physician or taking any medication?

YES NO 3. Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports?

YES NO 4. Does this athlete have any known allergies to medication?

YES NO 5. Does this athlete wear glasses or contact lenses? (Give date of last eye exam if yes)__

YES NO 6. Has this athlete ever blackened out or lost consciousness during physical activity?

If "yes" to any of the above, please specify.

We consent to the participation of the above-named athlete in the HNHS program.

_____ _____ _____
Student (18 yrs or older) Parent/Guardian Date

I hereby grant permission, in the case of injury, to have an athletic trainer, EMT, and/or medical doctor provide me with medical assistance and/or treatment.

_____ _____ _____
Student (18 yrs or older) Parent/Guardian Date