

**ATHLETIC DEPARTMENT  
ST. JOSEPH BY-THE-SEA HIGH SCHOOL  
HEALTH AND MEDICAL RECORD**

Last Name

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Team/Level \_\_\_\_\_

In case of emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Other person to contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

First

Middle

**HEALTH HISTORY**

Have you had: (Mark "past" or "not" or leave blank)

Sinus trouble _____	Asthma _____	Frequent diarrhea _____
Rheumatic Fever _____	Earache/Infection _____	Fainting spells _____
Epilepsy _____	Tuberculosis _____	Diabetes _____
Kidney disease _____	Heart Trouble _____	For girls: _____
Hay Fever _____	Severe stomach aches _____	Menstrual problems _____

Other allergies or reaction to any medication? \_\_\_\_\_

Do you tire easily? \_\_\_\_\_

Do you get out of breath easily? \_\_\_\_\_

Have you had more than a brief minor illness or injury during the past year? \_\_\_\_\_

If so, what? \_\_\_\_\_

Any condition now requiring regular medication or treatment? \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Any restriction of activity for medical reasons? \_\_\_\_\_

Explain: \_\_\_\_\_

**Parents' Authorization:**

*This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician/medical facility selected by the school/coach in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent / Guardian)

Team/Level

