

Medical History Form

Player Name: _____

Birth date: _____

If the answer to any of the following question is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following, please circle:

Head Injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	es	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No
Specify: _____		
Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other: _____	Yes	No
Impaired vision	Yes	No
Impaired hearing	Yes	No
Other: _____		

Parent/Guardian Signature: _____

Date: _____