HEALTH HISTORY UPDATE

Name _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:		
Asthma/Allergies:	Yes	No
Specify		
Concussion(s)	Yes	No
Diabetes	Yes	No
Seizure Disorder	Yes	No
Eye or Ear Condition	Yes	No
Heart Disease	Yes	No
Take any medication on a regular basis	Yes	No
specify		
SINCE LAST SPORTS' PHYSICAL		
Any illness lasting more than a week?	Yes	No
Specify		
Date(s)		
Any injuries?	Yes	No
Specify		
Date(s)		
Operations?	Yes	No
Specify		
Date(s)		

Parent Signature:_____ Date _____