LaFAYETTE JR./SR. HIGH SCHOOL

Prior to the start of the tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A – TO BE COMPLETED BY PARENT OR GUARDIAN

Student _____ Age _____

Date of Birth ____/____/____ Grade _____ Sport _____

Level: Modified _____ Junior Varsity _____ Varsity _____

PART B – TO BE COMPLETED BY PARENT OR GUARDIAN

NOTE: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office and will be kept confidential.

HISTORY SINCE LAST PHYSICAL: If the answer to any of the following questions is "YES", please describe the condition or situation that prompted your answer in PART C.

1. Any injuries requiring medical attention? ( ) Yes ( ) No
2. Any illness lasting more than five (5) days? ( ) Yes ( ) No
3. Taking medication or under a physician's care at this time? ( ) Yes ( ) No
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? ( ) Yes ( ) No
5. Change in wearing glasses or contact lenses? ( ) Yes ( ) No
6. Any surgical operations or fractures? ( ) Yes ( ) No
7. Any treatment in a hospital or emergency room? ( ) Yes ( ) No
8. Developed any allergies? ( ) Yes ( ) No
9. Any chronic disease? ( ) Yes ( ) No

PART C – TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES":

_____

_____

_____

PART D – PARENTAL SIGNATURE

I, the undersigned, declare that the answers above are correct to the best of my knowledge.

Signed _____ Date: _____

PART E – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Last Health Appraisal ____/____/____ Limitations: ( ) Yes ( ) No

Sports Participation ( ) Approved ( ) Referred to School Physician

Signed _____ Date ____/____/____

If Referred to the School Physician ( ) Re-qualified ( ) Disqualified

Signed _____ Date ____/____/____