

**STONINGTON PUBLIC SCHOOLS
SPORTS CANDIDATE HEALTH QUESTIONNAIRE**

Home Room _____

Name _____ Date of Birth _____

Address _____ School _____
Present _____

Sport _____ Grade _____

1. Check if yes and explain:

- | | |
|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Breathing Difficulties |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Arthritis |

Explanation: Please indicate body part (right or left), also approximate year of medical problem

2. Are you taking any medications now? List _____
3. Are you being treated for a medial problem now? _____
4. Recent immunizations? _____
5. Is there any problem that might interfere with your athletic performance? _____

_____ Parent Signature	_____ Student Signature
_____ Date	_____ Date

OFFICE USE - DO NOT WRITE IN THIS SPACE

Height _____	Medical Doctor _____
Weight _____	Date _____
Blood Pressure _____	Dental _____
Hematocrit _____	Scoliosis _____
Urinalysis _____	Problem Referred _____