

**Stonington Public Schools
Sports Candidate Health Questionnaire**

Home Room _____

Address _____ School _____

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"/> Vision 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 medical problem now? _____

4. Recent immunizations? _____

5. Is there any problem that might interfere with your athletic performance? _____

(Parent Signature)

(Student Signature)

(Date)

(Date)

OFFICIAL USE – DO NOT WRITE IN THIS SPACE

Hematocrit _____
Blood Pressure _____
Urinalysis _____
Height _____
Weight _____

Medical Doctor _____
Date _____
Problem Referred _____
Scoliosis _____

(7/2005/sm)