

**Bishop O'Connell High School
Sports Preparticipation Evaluation
Medical History**

This information should be completed by the parent and student prior to the physical examination.

Student's Last Name _____ First Name _____ Male ___ Female ___

Date of Birth ____/____/____ Grade for School Year 2010-2011 _____ Sport(s) _____

Allergies _____

Date of last Tetanus shot ____/____/____

Has student ever had any of the following—explain “Yes” answers:

- | | | | |
|--|------------------------------|-----------------------------|-------|
| Heart murmur | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| High blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Other heart problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Relative with heart problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Dizziness, chest pain or passed out after exercise | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Concussion | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Been knocked out | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Seizures or epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Muscle, bone or joint injuries | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Been hospitalized | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

Does student currently have any of these conditions—explain “Yes” answers:

- | | | | |
|---|------------------------------|-----------------------------|-------|
| Trouble breathing or cough after exercise | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Significant allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Adrenaline/inhaler prescription | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Take medicine regularly | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Illness lasting a week or more | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Blood disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Contacts, glasses, braces | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Missing/Non-functioning organ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Skin problem | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Special equipment for sports | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Any other significant health problem | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

Date ____/____/____

Signature of Student _____

Signature of Parent/Guardian _____