

SPLC Medical History Form

Player Name _____ **Date** _____

Birth date _____

If the answer to any of the following question is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following, please circle:

Head Injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No
Specify: _____		
Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other: _____	Yes	No
Impaired vision	Yes	No
Impaired hearing	Yes	No
Other: _____		

Have you had a recent tetanus booster? _____ If so, when? _____

Are you currently taking any medications? _____ What? Why? _____

Please explain any restrictions the doctor has placed on your activity? _____

Any other information that would be medically helpful? _____

Parent/Guardian Signature _____ **Date** _____

Team Reps: Please give original Medical History Form to the coach and keep a copy for your records.