

**Mercer Island High School  
ATHLETIC HEALTH FORM  
To be filled out by the student/parent**

Student \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Hm. Phone \_\_\_\_\_ Wk. Phone \_\_\_\_\_

Physician's Name (Please Print) \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Date of last Tetanus Immunization? \_\_\_\_\_ Date of last Measles Immunization? \_\_\_\_\_

Explain "Yes" answers below

- |   | No                    | Yes                   |
|---|-----------------------|-----------------------|
| 1. Overnight hospitalizations, operations or surgery? Dates   | <input type="radio"/> | <input type="radio"/> |
| 2. Are you presently taking any medication or pills?  | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have any allergies (medicine, bees or other stinging insects?)  | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever passed out during or after exercise?   | <input type="radio"/> | <input type="radio"/> |
| Have you ever been dizzy during or after exercise?  | <input type="radio"/> | <input type="radio"/> |
| Do you tire more quickly than your friends during exercise?   | <input type="radio"/> | <input type="radio"/> |
| Have you ever had high blood pressure?  | <input type="radio"/> | <input type="radio"/> |
| Have you ever been told that you have a heart murmur?   | <input type="radio"/> | <input type="radio"/> |
| Have you ever had racing of your heart or skipped heartbeats?   | <input type="radio"/> | <input type="radio"/> |
| Anyone under 50 yrs old in the family die of heart problems?  | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have any skin problems?   | <input type="radio"/> | <input type="radio"/> |
| 6. Have you ever had a head injury?   | <input type="radio"/> | <input type="radio"/> |
| Have you ever been knocked out or unconscious?  | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a seizure?  | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a stinger, burner or pinched nerve?   | <input type="radio"/> | <input type="radio"/> |
| 7. Have you ever had heat or muscle cramps?   | <input type="radio"/> | <input type="radio"/> |
| Have you ever been dizzy or passed out in the heat?   | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have trouble breathing or do you cough during or after activity?  | <input type="radio"/> | <input type="radio"/> |
| 9. Do you use any special equipment (pads, braces, mouth guard, etc)?   | <input type="radio"/> | <input type="radio"/> |
| 10. Have you had any problems with your eyes or vision?   | <input type="radio"/> | <input type="radio"/> |
| Do you wear glasses or contacts or protective eye or vision?  | <input type="radio"/> | <input type="radio"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? | <input type="radio"/> | <input type="radio"/> |
| o Head      o Shoulder      o Thigh      o Neck      o Elbow      o Knee      o Chest      o Foot                                     |                       |                       |
| o Forearm      o Shin/calf      o Back      o Wrist      o Ankle      o Hip      o Hand   |                       |                       |
| 12. Females Only: Have your menses begun? _____   |                       |                       |
| Do they come more often than once a month? _____ Less often than every two months? _____  |                       |                       |

Explain "Yes" answers to Questions 1-12 above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The signature below indicates that a parent/guardian and the participating student acknowledge they have carefully read this form and the above information is true.

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

