



Athletic Competition Health Form

St. Ignatius Martyr Catholic School



To be completed by Parent				To be completed by Physician							
Student Name:				Physician's Name:			Phone:				
Age:		Grade:		Physician's Address:							
Date of Birth:		Gender:									
HEALTH HISTORY					Vitals		Satisfactory:		Vision: R _____ L _____		Recommended Follow-up
Answer Yes or No ONLY			Yes	No			Yes	No	Hearing: 25 dB 1K 2K 4K		
					Ht:				Right: _____		
Chronic Illness					Wt:				Left: _____		
Hospitalization					BP:						
Surgery other than tonsils					General						
Injuries treated by physician											
Current medications											
Organs missing											
Heat exhaustion/stroke											
Dizziness, fainting, convulsions and/or headaches					Head						
Knocked unconscious											
Concussion											
Wear glasses/contacts					Eyes						
Hearing defects					Ears						
Dental appliances bridge/braces/plate					Dental						
Cough/pain					Chest						
Problems with blood pressure, heart or murmurs					Heart						
Problems with liver, spleen, or kidney					Abdomen						
Hernia					Genitalia						
Recurrent skin disease					Skin						
Bone/joint injury					Extremities						
Sprain/dislocation					Back/Neck						
Injury that caused a missed practice/event					Scoliosis Screening:						
Allergic to any medications? Name:					Allergy						
Tetanus booster in the last 10 years on Immunization Record?					Summary of comments:						
Parent/Guardian Signature:				Sports Participation: Yes No							
				notes:							
I certify that the above information is current and correct to the best of my knowledge:				Date		Physician Signature:				Date:	
						Physician Printed Name:					

Return to St. Ignatius Martyr Catholic School, 120 W. Oltorf Street, Austin, TX 78704