BASCS AD Form #11

A parent or guardian must complete this form**. This is NOT the physical exam form.**
HEATLH HISTORY: ***Must be completed and signed by a parent or guardian.***

Name: _____

Male _____ Female _____ Birth Date _____ Grade _____

Home address _____ Zip _____ Phone # _____

Work #_____ Cell #_____ Pager #_____

Identify any sports in which you do not wish your child to participate in:

_____

Has your child ever had?

	YES	NO		YES	NO
Anemia/Blood Disorders	____	____	Frequent Stomach Aches/Stomach Ulcer	____	____
Bladder/Kidney Problems	____	____	Frequent Nose Bleeds	____	____
Fainting Spells	____	____	Dental braces/bridges/plates/dental implants	____	____
Ear/Hearing Problems	____	____	*Anxiety/Depression/Emotional Problems*	____	____
Learning Disability	____	____	Nose fracture	____	____
Headaches/Dizziness	____	____	Elevated Blood Pressure	____	____
Frequent Sore Throat	____	____	Heart Problem/Murmur	____	____
Head Injury/Concussion	____	____	Rheumatic Fever	____	____
Fractures/Dislocations	____	____	Insect sting allergy	____	____
Skin Rashes	____	____	Injury to Spleen	____	____
Chicken Pox	____	____	Arthritis	____	____
Asthma	____	____	Joints pain/Ligament Tear	____	____
Diabetes/Hypoglycemia (low blood sugar)	____	____	Knee/Ankle problems	____	____
Eye/Vision Problems	____	____	Convulsions/Seizures	____	____
Contacts/Glasses	____	____			
Allergies/Environmental/Food	____	____	(please indicate what are the allergies) _____		

HAS YOUR CHILD EVER:

Been excused from Physical Education for more than two days? _____
Had an illness or injury that caused him/her to miss a game or practice?_____
Fainted, been unconscious or lost his/her memory?_____
Had an illness, condition or injury that required him/her to go to the hospital, either as a patient, overnight or in the ER? _____
Been ill for five (5) consecutive days?_____
Had severe uncorrectable loss of vision in one or both eyes?_____
Needed dialysis or had kidney surgery? _____
Is your child under medical care currently?_____ Surgery in the last 12 months?_____
Does your child take medication?_____ Name of med, time and dose: _____
Does your child carry an EPI-PEN for reaction to bee stings or peanuts?
Has there ever been a sudden death in a family member under 50 years of age?_____

PARENT OR GUARDIAN PERMISSION AND RELEASE: I hereby give my consent to the above named student to engage in approved athletic activities as a representative of his/her school, expect those activities indicated on the back by the licensed professional. I also give my permission for the team's coach, athletic trainer, and other qualified personnel to give first aid treatment to my son/daughter at an athletic event in case of injury.

Parent/Guardian Name **PRINTED**: _____ **SIGNATURE**:_____

Signature of Student Athlete:_____ Date:_____

190 Franklin Street, Buffalo, NY 1422 (716) 854-2490 **fax:** (716) 854-5039 **email:** contact@bascs.org