Do you wear glasses, contacts, other? Yes ___ No ___

Have you ever had:

Hearing loss or deafness? Yes ___ No ___

Perforated ear drum or "tubes" in ears? Yes ___ No ___

Draining ears? Yes ___ No ___

PART I – STUDENT'S HEALTH FOLDER

STUDENT'S MEDICAL HISTORY **CONTINUED:**

(To be filled out by student and parent) Clinician's Comments

Have you ever had:

Sinus problems or hay fever? Yes ___ No ___

Braces or removable teeth? Yes ___ No ___

Have you ever had:

Any broken bones? _____ Yes ___ No ___

Dislocation or other serious problems? Yes ___ No ___

Serious foot problem? Yes ___ No ___

Back injury or frequent backaches? Yes ___ No ___

Ankle or knee injury or problem? Yes ___ No ___

Other joint problems? Yes ___ No ___

Do you have a hernia? Yes ___ No ___

Boys: Any problems with testicles? Yes ___ No ___

Girls: Any menstrual problem? Yes ___ No ___

Age at first menstrual period? _____

Do you miss school because of your period? Yes ___ No ___

Have you ever had:

Diabetes? Yes ___ No ___

Single illness for more than 10 days? Yes ___ No ___

Any operations? Yes ___ No ___

Easy bruising or bleeding tendency? Yes ___ No ___

Anemia? Yes ___ No ___

Asthma? Yes ___ No ___

Bee sting allergy? Yes ___ No ___

Other allergies (food or medicine) Yes ___ No ___

Heart trouble or murmurs? Yes ___ No ___

High blood pressure? Yes ___ No ___

Cough lasting more than 3 weeks? Yes ___ No ___

Chest pain or faintness with exercise? Yes ___ No ___

Kidney problems? Yes ___ No ___

Skin infections? Yes ___ No ___

Do you take any medicines? Yes ___ No ___

Do you smoke? Yes ___ No ___

Have you ever been told not to play any sport because of your health? Yes ___ No ___

****

PHYSICAL EXAMINATION

A complete physical examination for all students is recommended. Omission of the Maturation Index will not disqualify a student from participation.

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision Uncorrected: L20/_____ R20/_____ Corrected: L20/_____ R20/_____

	Normal	Abnormal	Comments
Skin	_____	_____	_____
Eyes	_____	_____	_____
ENT	_____	_____	_____
Mouth & Teeth	_____	_____	_____
Neck	_____	_____	_____
Cardiovascular	_____	_____	_____
Lungs, Chest	_____	_____	_____
Spine	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (Hernia)	_____	_____	_____