

## OAK HILL HIGH SCHOOL SPORTS HEALTH UPDATE

Name	Age		D.O.B	
Grade		Sport		
<p>1. Since your last Physical have you had nay injuries requiring medical attention?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what?</p>				
<p>2. Have you lost consciousness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you had any fractures, sprains, or dislocations?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain:</p>				
<p>4. Are you presently under a Doctors care?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Doctor's Name: _____ Phone: _____</p>				
<p>5. Do you have any allergies?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what?</p>				
<p>6. Do you have Asthma?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what medications are you taking?</p>				
<p>7. Do you wear glasses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear contacts?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you wear braces?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p>				

*These questions have been answered to  
the best of our knowledge*

\_\_\_\_\_ Date

\_\_\_\_\_ Student's Signature

\_\_\_\_\_ Parent's Signature

**\*\*Completed forms must be returned to the coach before first practice of each sport session\*\***