

Stonington Public Schools
Sports Candidate Health Questionnaire

Home Room _____

Name _____ Date of Birth _____

Address _____

School _____ Sport _____ Grade _____

1. Please Check if the Student has a History of Any of the Following and Explain:

- | | | | |
|---|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Concussion | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mono |

Explanation: Please indicate body part (right or left); also approximate year of medical problem.

2. Is the student taking any medications now? List _____

3. Is the student being treated for any medical problems now? _____

4. Did the student have any recent immunizations? _____

5. Are there any problems that might interfere with the student's athletic performance? _____

6. I prefer to have my son/daughter examined by:

- Our Family Physician Dr. Michael Blefeld, School Physician

Parent Signature _____ Date _____

Student Signature _____ Date _____

OFFICE USE – DO NOT WRITE IN THIS SPACE

Height	_____	Medical Doctor	_____
Weight	_____	Date	_____
Blood Pressure	_____	Dental	_____
Hematocrit	_____	Scoliosis	_____
Urinalysis	_____	Problem Referred	_____