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:

☐ Seizures	☐ Hepatitis	☐ Anemia	☐ Diabetes
☐ Heart Problems	☐ Bleeding Disorder	☐ Concussion	☐ Fractures
☐ Breathing Difficulties	☐ Visual Problems	☐ Allergies	☐ Surgery
☐ Hospitalization	☐ Hearing Problems	☐ Arthritis	☐ 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	_____