GASTON DAY SCHOOL

MEDICAL HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT)

Name _____ Date _____

Date of Birth _____ Gender _____ 2020-21 Grade _____

Please answer the following questions.	**Yes**	**No**
1. Do you experience frequent headaches?	___	___
2. Do you ever have dizzy spells?	___	___
3. Have you ever fainted?	___	___
4. Have you ever had a seizure?	___	___
5. Have you ever had a concussion?	___	___
6. Have you ever lost consciousness?	___	___
7. Have you had a head or neck injury?	___	___
8. Have you ever experienced temporary paralysis, numbness, tingling or weakness of any extremities?	___	___
9. Have you ever had any eye problems?	___	___
10. Have you had problems with your hearing or with your ears?	___	___
11. Do you experience frequent nosebleeds?	___	___
12. Do you have frequent sore throats?	___	___
13. Do you have any skin disorders?	___	___
14. Do you ever have chest pain?	___	___
15. Do you have a heart murmur?	___	___
16. Do you have high blood pressure?	___	___
17. Is heart disease present in your family?	___	___
18. Has anyone in your family died suddenly or at a young age (<50) of a heart attack?	___	___
19. Do you have any stomach or intestinal problems (ulcers)?	___	___
20. Have you ever had any problems urinating, unusual discharge, or blood in your stools or urine?	___	___
21. Do you have any kidney problems?	___	___
22. Have you ever had any abdominal pain?	___	___
23. Do you have arthritis?	___	___
24. Do you have joint pain or swelling?	___	___
25. Have you had any broken bones?	___	___
26. Have you ever had any shoulder, elbow, wrist, back, hip, knee, or ankle injuries?	___	___
27. Does any joint feel as if it slipping or is going to give out?	___	___
28. Have you ever had any surgeries?	___	___
29. Have you suffered heat stroke or heat exhaustion?	___	___
30. Do you have only one of any paired organs?	___	___
31. Have you had any other major injuries/conditions not covered above?	___	___
32. Have you ever been denied participation in any sporting event due to a medical problem?	___	___
33. Do you have asthma?	___	___
34. Do you have allergies?	___	___
35. Do you wear glasses or contact lenses?	___	___

If you answered **YES** to any questions, please explain as necessary on the reverse side of this page.

This form has been completed honestly and to the best of my knowledge.

Signature of Parent/Legal Guardian_____Date_____

Signature of Student_____Date_____

GASTON DAY SCHOOL
MEDICAL EXAMINATION FORM

NAME _____
HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____
PULSE _____

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
ENT			
Heart			
Lungs			
Abdomen			
Genitalia (males only)			
Musculoskeletal			
Neurological			
Skin			

LABORATORY

OTHER (INDICATED)_____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE NAMED STUDENT AND THAT SUCH EXAMINATION REVEALED (CONDITIONS/NO CONDITIONS) THAT WOULD PREVENT THIS STUDENT FROM PARTICIPATING IN THE INTERSCHOLASTIC SPORTS.

LICENSED TO PRACTICE MEDICINE IN NC? YES NO

SIGNATURE_____ Date of Exam _____

ADDRESS/CITY/STATE/ZIP_____

IF STUDENT IS NOT QUALIFIED, LIST REASONS FOR DISQUALIFICATION:
_____

_____

THE FOLLOWING ARE CONSIDERED DISQUALIFYING UNTIL MEDICAL AND PARENTAL RELEASES ARE OBTAINED: ACUTE INFECTIONS, OBVIOUS GROWTH RETARDATION, DIABETES, JAUNDICE, SEVERE VISUAL OR AUDITORY IMPAIRMENT, PULMONARY INSUFFICIENCY, ORGANIC HEART DISEASE OR HYPERTENSION, ENLARGED LIVER OR SPLEEN, HERNIA, MUSCULOSKELETAL DEFORMITY ASSOCIATED WITH FUNCTIONAL LOSS, HISTORY OF CONVULSIONS OR CONCUSSIONS, ABSENCE OF ONE KIDNEY, EYE OR TESTICLE.