

SECTION 6: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1.			23.		
2.			24.		
3.			25.		
4.			26.		
5.			27.		
6.			28.		
7.			29.		
8.			30.		
9.			CONCUSSION OR TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No 33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> High blood pressure			34.		
<input type="checkbox"/> High cholesterol			35.		
<input type="checkbox"/> Heart murmur			36.		
<input type="checkbox"/> Heart infection			37.		
10.			38.		
11.			39.		
12.			40.		
13.			41.		
14.			42.		
15.			43.		
16.			44.		
17.			45.		
18.			46.		
19.			FEMALES ONLY		
20.			47.		
21.			48.		
22.			49.		
			50.		

#s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____