BUNCOMBE COUNTY SCHOOLS
Athletic Competition Health Screening Form

Name: _____ Age: _____ Sex: _____ School: _____

VITALS: Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

HEALTH HISTORY

The following information is ESSENTIAL and MUST be completed by parent or guardian.

Answer "yes" or "no" only	Yes	No
Chronic/Recurrent Illness?		
Previous hospitalization?		
Surgery other than tonsils?		
Injuries treated by a physician?		
Current medications?		
Organs missing?		
Heat exhaustion/stoke/cramps?		
Dizziness, fainting, convulsions and/or headaches?		
Ever been knocked out?		
Any history of concussion?		
Wear glasses or contacts?		
Any hearing defects?		
Any dental appliances bridge/braces/cap/plate?		
Cough/pain/short of breath/asthma?		
Problems with blood pressure heart or history of murmurs?		
Problems with liver, spleen, kidneys, or pancreas?		
Any hernias?		
Recurrent skin disease?		
Bone/joint injury? sprain/dislocation?		
Any injury that caused a missed practice/event?		
Allergy to medications? Name:		
Tetanus booster in last 10 years? Date:		

	Normal		Physical Evaluation Comments	Follow-Up Needed
	Yes	No		
General				
Head				
Eyes			Acuity R L	
ENT				
Dental				
Chest				
Heart				
Abdomen				
Skin				
Neck				
Back				
Shoulders			R	
			L	
Elbows			R	
			L	
Wrist/Hand			R	
			L	
Hips			R	
			L	
Knees			R	
			L	
Ankle/Foot			R	
			L	

The above information is current and correct to the best of my knowledge:

_____
Signature of Parent/Guardian

_____
Date

Summary of Comments/Recommendations:

Sports Participation Approved: YES _____ NO _____

Limitations/Recommended Follow-up:

_____ _____
Physician's Signature Date