

**BUNCOMBE COUNTY SCHOOLS**  
**Athletic Competition Health Screening Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ School: \_\_\_\_\_

VITALS: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

<b>HEALTH HISTORY</b> The following information is ESSENTIAL and MUST be completed by parent or guardian.				Normal		Physical Evaluation Comments	Follow-Up Needed
				Yes	No		
				General			
				Head			
Answer "yes" or "no" only				Eyes		Acuity	R L
Chronic/Recurrent Illness?	Yes	No		ENT			
Previous hospitalization?				Dental			
Surgery other than tonsils?				Chest			
Injuries treated by a physician?				Heart			
Current medications?				Abdomen			
Organs missing?				Skin			
Heat exhaustion/stroke/cramps?				Neck			
Dizziness, fainting, convulsions and/or headaches?				Back			
Ever been knocked out?				Shoulders		R	
Any history of concussion?							L
Wear glasses or contacts?				Elbows		R	
Any hearing defects?							L
Any dental appliances bridge/braces/cap/plate?				Wrist/Hand		R	
Cough/pain/short of breath/asthma?							L
Problems with blood pressure heart or history of murmurs?				Hips		R	
Problems with liver, spleen, kidneys, or pancreas?							L
Any hernias?				Knees		R	
Recurrent skin disease?							L
Bone/joint injury? sprain/dislocation?				Ankle/Foot		R	
Any injury that caused a missed practice/event?							L
Allergy to medications? Name:				Summary of Comments/Recommendations:			
Tetanus booster in last 10 years? Date:							
The above information is current and correct to the best of my knowledge:				Sports Participation Approved: YES _____ NO _____  Limitations/Recommended Follow-up:  _____			
Signature of Parent/Guardian							
Date							
				Physician's Signature		Date	