

St. Bridget Health History Form

Name: _____ Age: _____
Address: _____ Telephone: _____
Mother's Name: _____ Father's Name: _____
Phone #: (H) _____ (W) _____ Phone #: (H) _____ (W) _____
Cell #: _____ Cell #: _____
Family Physician: _____ Phone: _____
Hospital Preference: _____

Previous Injuries: (Please check each area that has been injured and explain below.)

- | | | | |
|----------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|
| a) Head <input type="checkbox"/> | e) Hips <input type="checkbox"/> | i) Ankle <input type="checkbox"/> | m) Elbow <input type="checkbox"/> |
| b) Neck <input type="checkbox"/> | f) Thigh <input type="checkbox"/> | j) Foot <input type="checkbox"/> | n) Forearm <input type="checkbox"/> |
| c) Ribs <input type="checkbox"/> | g) Knee <input type="checkbox"/> | k) Shoulder <input type="checkbox"/> | o) Wrist <input type="checkbox"/> |
| d) Back <input type="checkbox"/> | h) Lower Leg <input type="checkbox"/> | l) Arm <input type="checkbox"/> | p) Hand <input type="checkbox"/> |

Comments: _____

Illness: (Please indicate and explain any illness that may be present i.e. Asthma, Diabetes, Epilepsy, Cancer, Heart Trouble, High Blood Pressure, Bleeding Tendencies, Missing Paired Organs, etc.)

Comments: _____

Medications: (Please indicate any medications taken on a regular basis.)

Comments: _____

Allergies: (Please indicate any allergies to medications and/or insect bites or stings, also reactions to medications and/or insect bites or stings) or food.

Comments: _____

Name: _____ is in good health and may play soccer/basketball/baseball/softball.

Doctor's Signature: _____ Date: _____

Doctor's Name (Print): _____

**Health form must be returned prior to first game.
No physical participation allowed without completed health form on file!**

St. Bridget School
171 Main Street • Cheshire • CT • 06410
www.stbridgetschool.org