

**Hamilton High School
Sports Medicine
Information Sheet**

Date _____ / _____ / _____
(Month Day Year)

Name _____ Sport _____
Last, First

Date of Birth _____ / _____ / _____ Grade Level 9th 10th 11th 12th
Month Day Year

Insurance Information

Company Name _____

Policy # _____

Health History

Allergies (Medication, Food , Others) _____

Asthma Yes No _____
(Medication or Inhaler Used)

Sickle Cell Trait Yes No

Diabetes Yes No

Epilepsy Yes No

Heat Illness Yes No _____
(Explain)

Concussion Yes No _____
(Date of last Concussion)

Medication currently being taken _____

List Serious Illness/ Injury/ Surgery (Month/ Year) _____
