

**Ohio Gators  
BASKETBALL ORGANIZATION CORPORATION  
MEDICAL HISTORY**

**To the parents of the athlete: Please complete this Medical History for every athlete in the program. Information supplied will become a part of your child's health record. All health records are confidential.**

Athlete's Name(last)                      Sex                      (first)                      (MI)                      Social Security #

Father's Name    Mother's Name

Home Phone    Father's Work Phone    Mother's Work Phone

Street Address

City    State    Zip Code

Birthdate    Age    Height    Weight

**REPORT OF MEDICAL HISTORY**

Name of Physician    Phone Number

Does your child have any allergies?  Yes  No

- Aspirin
- Bee Stings
- Sulfa
- Eggs
- Pollens/Ragweed

- Tetanus/Toxoid
- Molds/Fungi
- Codiene
- Penicillin
- OTHER \_\_\_\_\_

Immunization required prior to registration: (Please attach proof of test or vaccination)

Please place an "X" in the appropriate column if your child has or had any of the following illnesses:

<input type="checkbox"/>	Measles (Red)
<input type="checkbox"/>	German Measles
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Malaria
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Gum/Tooth Trouble
<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Eye Problems
<input type="checkbox"/>	Ear Problems
<input type="checkbox"/>	Recurrent Colds
<input type="checkbox"/>	Tumor, Cancer, Cyst
<input type="checkbox"/>	Hay Fever/Asthma
<input type="checkbox"/>	DES Exposure
<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	Tonsillectomy

<input type="checkbox"/>	Hernia Repair
<input type="checkbox"/>	Other Surgery (Note Below)
<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Recurrent Headache
<input type="checkbox"/>	Recurrent Bladder Infection
<input type="checkbox"/>	Kidney Infection
<input type="checkbox"/>	Head Injury /Unconsciousness
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Chest Pain /Pressure
<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	Palpitation (Heart)
<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Joint Disease

<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Seizures/Convulsions
<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Gallbladder Trouble
<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	Recurrent Diarrhea
<input type="checkbox"/>	Recent Weight Gain/Loss
<input type="checkbox"/>	Dizziness/Fainting
<input type="checkbox"/>	Weakness, Paralysis
<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	Other Infectious Disease

Explanation: \_\_\_\_\_