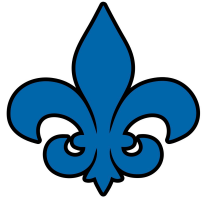




Saints Hockey
2025-2026 Optional Health History Form



For Parent/Guardian Completion Only:

Last _____ First _____

Address: _____ City _____ State _____

Telephone Number: _____ Date of Birth: _____

Player Level (Circle One) JV Varsity

Participant Medical History:

- | | | |
|--|-----|----|
| 1. Is there any history of concussion and/or head injuries? | YES | NO |
| 2. Does the participant have any allergies (bee stings, food, etc)? | YES | NO |
| 3. Does the participant have asthma/require the use of an inhaler? | YES | NO |
| 4. Is the participant currently taking any medications? | YES | NO |
| 5. Does/has the participant have/had seizures? | YES | NO |
| 6. Does the participant wear glasses or contact lenses? | YES | NO |
| 7. Does the participant have any other physical limitations or medical conditions? | YES | NO |

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form:

I hereby certify that this information is accurate to the best of my knowledge.

Signature of Parent or Legal Guardian: _____

Print Name: _____ **Date:** _____