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OPENS DOORS TO THE FUTURE

Athlete information and Medical History

Athlete's Info

Name:____ Year in School: Fr So Jr Sr 5th yr

Sex: M F Birthdate:_____________________________ Sport:_______________________________

Address (Local):_________________________City:____________State:___________Zip:___________

e-mail:___________________________________Cell:____

Marital Status: Single Married Divorced Widowed Separated Spouse:__________________________

Parents Info

Father		Mother	
Name:		Name:	
Address:		Address:	
City/State:		City/State:	
e-mail:		e-mail:	
Phone:	Cell:	Phone:	Cell:

Person to Notify in Case of Emergency

Name:____Relationship:______________________________

Phone:____Cell:___________________________________

Allergies: (Medications, Food, Environmental, Insect bites/stings)

Allergy	Reaction

Medications Taken on a Regular Basis:

Medication	Dose	Frequency (dialy, 2x dialy etc.)

List any Surgies Illnesses or Hospitalizations in the Past 2 Years

Medical Reasons for Hospitalizations	Date	Type of Surgery	Date

Athlete Information and Medical History

Do you have or have you been told you have any of the following?

Condition	Y	N	Condition	Y	N
Asthma/Exercise Induced Asthma			Heat Related Illness (Exuastion/stroke)		
Mononucleosis			Epilepsy/Seizures		
Diabetes			Nose Bleeds		
Excessive Fatigue with Exercise?			Exposure to Tuberculosis (TB), HIV, Hepatitis		
Concussion/Loss of Consciousness			Sickle Cell Disease		
Chest pain, discomfort or palpitations?			Fainting spells or dizziness with exercise?		
Excessive or unexpected shortness or breathe with exercise?			Loss of/Impaired-organ function (eye, kidney, testicle, spleen)		
History of heart murmur?			Elevated Blood Pressure		
Family history of sudden death or someone in the family?			Family history of severe cardiac disease or heart condition?		
Family history of Martan's disease?			Diabetes		
For MEN: Hernia or Hernia Surgery?			For WOMEN: Positive pregnancy test in the last year?		

List any Orthopedic Injuries Within the Past 2 Years

Injury	Y	N	Date	Comment	Injury	Y	N	Date	Comment
Head									
Neck									
Back									
Shoulder									
Arm/Elbow									
Hand/Wrist									

Nutrition, Drugs, Food Supplements, and Miscellaneous Agents:

Have you ever used the following:	Never	Occasionally	Frequently
Stimulants (Benzedine, Amphetamines, etc)			
Chewing Tobacco, Snuff or Smokeless Tobacco			
Cigarettes, Cigars or Pipe			
Vitamins			
Diet Pills			
Alcoholic Beverages			
Amino Acids (Energy Drinks)			
Any other diet, nutritional or performance drug			

Family Physician: ________________________City: ______________________Phone: _________________

I certify that all the above information is true and accurate to the best of my knowledge. I have no abnormality, limitation or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

____

Athlete Signature Date

Athletic Training Medical History Questionnaire

(This will be kept Confidential)

Personal Information

Date:	Sport(s):
Name:	Age:
Height:	Weight:
Parent/Guardian:	Phone:
Campus Address:	Home Address:

PERSONAL HISTORY: Please answer all questions and explain all yes answers on back. Identify each explanation with the corresponding number.

Have you had…	Y	N	Have you had…	Y	N
Infectous Mononucleosis			Recurrent Diarrhea		
Jaundice			Eye Injury Disease		
Hepatitis			Wear Glasses During Competition		
Diabetes			Wear Contacts During Competition		
Epilepsy/Seizures			Ulcers		
Rheumatic Fever			Abdominal Pain		
General Surgery			Hemorrhoids		
Tonsillectomy			Urinary Tract Disease		
Appendectomy			Hernia		
Other			Wear Dental Appliance		
Hives			Disease/Injury Joints		
Eczema			Low Back Injury		
Acne			Neck Injury		
Dizziness/Fainting			Shoulder Injury (ie. Dislocation)		
Frequent Headaches			Elbow Injury		
Head Injury/Concussion			Hand/Wrist/Finger Injury		
Hearing Loss/Impairment			Hip Injury		
Sinus Infection			Knee Injury		
Recurrent Tonsillitis			Ankle Injury		
Recurrent Strep Throat			Foot Injury		
Bronchi's			Surgery Related to Joint Injury		
Pneumonia			Fracture in Lest 2 Years		
Chronic Colds/Cough			Pin, Screw, Plate in body		
Hay Fever/Asthma			Bone Grail or Spinal Fusion		
High Blood Pressure			Special Braces, Splints or Pads?		
Recent Loss/Increase Weight			Other		
Heart Murmur					

	Yes	No
Have you had any serious injury/illness, broken bones, surgery, or hospitalization other than already noted?		
Do you have any other medical concerns other than those noted?		
Are you allergic to any drugs, serum, medication, food, insects, etc?		

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If so, explain:		
Are you taking any medication or allergy shots on a regular basis?		
Have you ever been advised by a medical doctor not to participate in any sport? If so, list below.		

Date of last Medical Examination/Physical by a physician____

Number	**Explanation**

Number	**Medical Changes Since Last Year**

All of the above questions have been answered completely and truthfully to the best of my knowledge,

Freshman	Student Signature:	Date:
	Parent/Guardian Signature: (If athlete is under 18)	Date:
Sophomore	Student Signature:	Date:
Junior	Student Signature:	Date:
Senior	Student Signature:	Date:

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Physical Examination

Date: ____________________

Name: ______________________________ Date of Birth:__________________________ Sex: M/F

Sport: _______________________________

Height: _________ Weight: _________ Body Comp: __________ Pulse: __________ BP_________

Vision: R 20/_____ L 20/_____ Corrected: Y/N Glasses: _____________ Contacts: ________________

Medical	**Normal**	**Abnormal**	**Initial**
Appearance			
Skin			
Eyes			
Ears/Nose/Throat			
Lymph Nodes			
Dental			
Heart			
Lungs			
Abdominal (Hernia, masses, tenderness)			
Genitalia Males Only (Hernia, testicles)			

Musculoskeletal

Neck			
Back			
Posture			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Lower Leg/Ankle			
Foot/Arches			
Flexibility			
Strength			

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Student/Athlete's Name: ____

Sport: ____

Cleared: ______________________

Restrictions:

____

____

Not Cleared: ________________________ Reason: ____

Recommendations: ____

Name of the Physician (print/type): ____

Address: ____ Phone: _________________________

Signature of Physician: ____