LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FIRST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_

SEX: MALE \_\_\_\_\_FEMALE \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_Sports:\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

|  |  |  |
| --- | --- | --- |
| Have you had a medical illness or injury since your last check up or sports physical? |  |  |
| Have you had surgery in the past 5 years? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **Are you currently taking any medications?** |  |  |
| **List Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| Are you currently taking any supplements? |  |  |
| List supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Are you allergic to any medications or foods? |  |  |
| List allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Are you allergic to bee stings? |  |  |
| Do you carry an epi-pen? |  |  |
| Have you ever passed out during or after exercise? |  |  |
| Have you ever had chest pains during or after exercise? |  |  |
| Have you or a family member had high blood pressure or high cholesterol? |  |  |
| Have you ever been told you have a heart murmur or heart condition? |  |  |
| Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Do you wear glasses, contacts, or other protective eyewear? |  |  |
| Do you have any hearing deficits? |  |  |
| Do you use any special protective equipment that isn’t usually used for your sport? |  |  |
| Have you ever been treated for MRSA or other skin infection? |  |  |
| Have you ever had a head injury or concussion? |  |  |
| How many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of most recent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you ever been knocked out, become unconscious or lost your memory? |  |  |
| Do you have frequent or severe headaches/migraines? |  |  |
| Have you ever had a neck injury? |  |  |
| Have you ever had numbness or tingling in your arms, hands, legs or feet? |  |  |
| Have you ever had a stinger, burner or pinched nerve? |  |  |

**Have you had or do you currently have any of the following: please circle**

Mononucleosis Pneumonia Diabetes Anemia Epilepsy Heat Stroke Hernia

Kidney problems Sickle Cell Trait Asthma

**Have you had any problems with any of following? Please circle and explain.**

Back Neck Chest Shoulder Elbow Wrist/Hand Hip/Thigh Knee

Ankle/Foot Spinal Fusion Joint Dislocation Cartilage Injury Osgood-Schlatter’s

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a physician ever denied or restricted your participation in sports for any reason? YES NO

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

**Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

