

MEDICAL HISTORY

Student's Name: _____ Age: _____ School: _____

***** PARENTS/GUARDIANS: Please assure all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.**

GENERAL MEDICAL HISTORY	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below (check all that apply): <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Infections <input type="checkbox"/> Other			28. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in a hospital?			29. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			30. Were you without or are you missing a kidney, eye, testicle, spleen, or any other organ?		
HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Do you or someone in your family have sickle cell trait or disease? Who?			32. Have you had infectious mononucleosis in the last month?		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?			33. Do you have any rashes, sores, or other skin problems?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you had a herpes or MRSA skin infection?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Do you have a history of seizure disorders?		
9. Has a doctor every told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other:			36. Have you ever had a head injury or concussion? If yes, how many have you had? (list dates) _____		
10. Has a doctor ever ordered a test for your heart? (Ecg/Ekg, echocardiogram, etc.)			37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Do you get lightheaded or feel more short of breath than expected during exercise?			38. Do you have headaches with exercise?		
12. Have you ever had an unexplained seizure?			39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?			40. Have you ever been unable to move your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	41. Have you ever become ill while exercising in the heat?		
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			42. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			43. Have you had any problems with your eyes or vision?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			44. Have you had an eye injury?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			45. Do you wear glasses or contact lenses?		
BONE AND JOINT QUESTIONS	Yes	No	46. Do you wear protective eyewear, such as goggles or a face shield?		
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			47. Do you worry about your weight?		
19. Have you ever had any broken, fractured or dislocated joints?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			49. Are you on a special diet or do you avoid certain food?		
21. Have you ever had a stress fracture?			50. Have you ever had an eating disorder?		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			51. Do you have any concerns you'd to discuss with the doctor?		
23. Do you regularly use a brace, orthotics, or other assistive device?			FEMALES ONLY	Yes	No
24. Do you have a bone, muscle, or joint that bothers you?			52. Have you ever had a menstrual period?		
25. Do any joints become painful, swollen, warm, or red?			53. How old were you when you had your first period?		
26. Do you have any history of arthritis or tissue disease?			54. How many periods have you had in the last month?		

Explain "Yes" answers:

***** PARENTS SIGN LAST PAGE BOLD BOX *****

I have reviewed and answered each question on the previous page, and assure that all responses are accurate.

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Physical Examination: to be completed by a licensed physician, nurse practitioner or physician's assistant:

Student's Name: _____ Date of Birth: _____ Sport(s): _____

Height _____ Weight _____ Vision R/20 _____ L 20/ _____ Corrected: Y N

Pulse _____ BP (R arm) seated _____ / _____ BP Re-Check (R arm) seated _____ / _____

⊗ This section to be completed by Physician

Medical	Normal	Abnormal Findings
Appearance <ul style="list-style-type: none"> Marfan Stimata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph Nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis, etc. 		
Neurologic ^c		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Movement		

^a Consider ECG, echo, and referral to cardiology for abnormal cardiac history or exam; ^b Consider GU exam in private setting with third party; ^c Consider cognitive evaluation or testing if significant concussion history.

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for

NOT cleared → → Pending further evaluation For any sports For certain sports

Reason: _____
 Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) outlined above. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are explained to the student (and parents/guardians) and parents/guardians have had the opportunity to ask questions.

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD / DO / NP / PA

CONCUSSIONS AND STUDENT-ATHLETES

After reading the Concussion and Student-Athletes Fact Sheet for Parents/Legal Guardians and Student-Athletes information I am aware of the following:

Student-Athlete Initials		Parent/Guardian Initials
	A concussion is a brain injury and should be reported to my coaches, athletic trainer, and parents.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance	
	A concussion may not be "seen." Some symptoms may not present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parent, coach, or athletic trainer about my injuries and illnesses.	NA
	If I think a teammate has a concussion, I should tell my coaches, parents, or athletic trainer about the concussion.	NA
	I will not return to play in a game or practice if a hit to my head or body causes any concussion related symptoms.	NA
	I will/my child will need written permission from a medical doctor trained in concussion management to return to play following a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not/cannot provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is more likely to sustain another concussion or more serious brain injury if return to play or practice occurs before symptoms are fully resolved.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the concussions and Student Athletes Form.	

I have read and understand the above information regarding concussions

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Return to Play Progression: Once cleared by a physician, the student-athlete will be returned to play in a stepwise fashion. These rules follow current best practices and are consistent with the NATA 2014 position statement for concussion management. Progression should be under the guidance of a coach or medical professional.

Day 1: Low levels of physical activity (i.e. symptoms do not come back during or after the activity). This includes walking, light jogging, light stationary biking, and light weightlifting (low weight – moderate reps, no bench, no squats).

Day 2: Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate intensity on the stationary cycle, moderate intensity weightlifting (reduce time and or reduced weight from your typical routine).

Day 3: Heavy non-contact physical activity. This includes sprinting/running, high intensity stationary cycling, completing the regular lifting routine, non-contact sport specific drills (agility – with 3 planes of movement).

Day 4: Sports specific, non-contact practice

Day 5: Full contact participation (Preferably in a controlled practice setting)

Day 6: No restrictions