



AHSA MEDICAL HISTORY EVALUATION



PART I: INFORMATION *(To be filled out by parent or guardian only)*

Name: _____ Grade: _____ School: _____ Sex: M / F

Age: _____ Date of Birth: _____ Home Telephone #: _____ Sports: _____

Social Security Number: _____ Address: _____ City: _____ Zip: _____

Parent's Name: _____ Parent's Employer: _____ Work Telephone #: _____

Insurance Company: _____ Policy #: _____ Family Doctor: _____

PART II: MEDICAL HISTORY *(To be filled out by parent or guardian)*

Has or Does this athlete

Circle & please explain all "yes" answers below

- | | | |
|--|----------------------------------|--------------------|
| 1. Have a medical problem or injury since his/her last evaluation? | YES | NO |
| Ever not been allowed to participate in sports for a medical reason? | YES | NO |
| 2. Ever been hospitalized? | YES | NO |
| Ever had surgery? | YES | NO |
| Have any missing organs? (<i>eye, kidney, testicle, etc.</i>) | YES | NO |
| 3. Presently take any medication? | YES | NO |
| 4. Have any allergies to medicine or insect bites? | YES | NO |
| 5. Passed out during or after exercise? | YES | NO |
| Been dizzy or passed out during or after exercise? | YES | NO |
| Have chest pain during or after exercise? | YES | NO |
| Tire more quickly than his/her friends during exercise? | YES | NO |
| Have high blood pressure? | YES | NO |
| Been told he/she has a heart murmur? | YES | NO |
| Have racing of the heart or skipped heartbeats? | YES | NO |
| Have a family member that died of heart problems or sudden death before age 50? | YES | NO |
| 6. Have any skin problems? | YES | NO |
| 7. Ever had a head or neck injury? | YES | NO |
| Ever been knocked out or unconscious? | YES | NO |
| Ever had a seizure? | YES | NO |
| Ever had a stinger, burner or pinched nerve? | YES | NO |
| 8. Ever had heat cramps? | YES | NO |
| Ever been dizzy or passed out in the heat? | YES | NO |
| 9. Have trouble with breathing or coughing during or after activity? | YES | NO |
| 10. Use any special equipment? (<i>pads, braces, neck rolls, eye guards, kidney belt, etc.</i>) | YES | NO |
| 11. Have any problems with vision? | YES | NO |
| Wear glasses or contacts? | YES | NO |
| 12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? | YES | NO |
| 13. Have any medical problems listed below? (<i>Please check off</i>) | | |
| _____ High Blood Pressure | _____ Rheumatic Fever | _____ Diabetes |
| _____ Mononucleosis | _____ Abnormal Bleeding | _____ Tuberculosis |
| _____ Sickle Cell Disease/Trait | _____ Other(<i>list</i>) _____ | |

14. List dates for last: Tetanus Shot: _____ Measles Immunization: _____

15. Female athletes, list dates for: First menstrual period: _____ Last menstrual period: _____

Longest time between periods last year: _____

Please explain all "yes" answers from above: _____

PART III: SIGNATURES

(You must answer these questions and sign for your child to be examined)

- | | | | |
|----|---|-----|----|
| 1. | The information on the reverse is current and correct to the best of my knowledge | YES | NO |
| 2. | I give my permission for my child to be examined for school-related activities | YES | NO |
| 3. | If, in the judgment of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary | YES | NO |
| 4. | I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed | YES | NO |
| 5. | I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately | YES | NO |
| 6. | I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school..... | YES | NO |

Signature of Parent/Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

PART IV: PHYSICAL *(To be filled out by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)*

	Height	Weight		Blood Pressure	/	Pulse
	SYSTEM	NORMAL	ABNORMAL	INITIALS		COMMENTS
	Heart					
	Lung					
	Other					
	Abdominal					
	Genitalia					
	Neck					
	Shoulder					
	Elbow					
	Wrist					
	Hand					
	Back					
	Knee					
	Ankle					
	Foot					
	Eye	Right 20/	Left 20/	Corrected?	YES /	NO

CLEARANCE: _____ A. Cleared
 _____ B. Cleared after further evaluation/treatment
 _____ C. Not cleared for: _____ Collision _____ Contact _____ Non-contact

RECOMMENDATIONS: _____

NAME OF MD/NURSE PRACTITIONER: _____ **DATE:** _____

ADDRESS: _____ **TELEPHONE:** _____

SIGNATURE OF MD/NURSE PRACTITIONER: _____