



Athlete Information

Name _____ DOB _____ Sex M F Class of _____
 Sports Fall _____ Winter _____ Spring _____

Emergency Contact Information

Parent/Guardian _____ Phone # _____ Cell # _____
 Parent/Guardian _____ Phone # _____ Cell # _____

Insurance Information

Name of Insurance Co. _____ Plan type HMO PPO Other
 Pediatrician _____ Phone # _____

Answer all of the following questions to the best of your knowledge. Please explain all "YES" answers.

- YES___ NO___ 1 Have you had a medical illness or injury since your last checkup or sports physical?
Explain: _____
- YES___ NO___ 2 Do you have a chronic or ongoing illness?
Explain: _____
- YES___ NO___ 3 Have you ever been hospitalized overnight?
Explain: _____
- YES___ NO___ 4 Have you ever had surgery?
Explain: _____
- YES___ NO___ 5 Do you have any allergies (i.e. pollen, medicine, food, insect bites)?
Explain: _____
- YES___ NO___ 6 Have you ever had a rash or hives during or after exercise?
Explain: _____
- YES___ NO___ 7 Are you currently taking any prescription or nonprescription medications?
Explain: _____
- YES___ NO___ 8 Have you ever taken any supplements or vitamins to help you gain or lose weight to improve performance?
Explain: _____
- YES___ NO___ 9 Have you ever passed out or been dizzy during or after exercise?
Explain: _____
- YES___ NO___ 10 Have you ever had chest pain during or after exercise?
Explain: _____
- YES___ NO___ 11 Have you ever had racing of the heart/skipped heartbeats, or a heart murmur?
Explain: _____
- YES___ NO___ 12 Have you ever had high blood pressure or high cholesterol?
Explain: _____
- YES___ NO___ 13 Has any family member or relative died of heart problems or of sudden death before the age of 50?
Explain: _____
- YES___ NO___ 14 Have you had a severe viral infection (i.e. myocarditis, mononucleosis, etc.) within the past year?
Explain: _____
- YES___ NO___ 15 Has a physician ever denied or restricted your participation in sports for any heart problems?
Explain: _____
- YES___ NO___ 16 Have you ever become ill from exercising in the heat, experienced heat cramps, or heat exhaustion?
Explain: _____
- YES___ NO___ 17 Do you cough, wheeze, or have trouble breathing during or after exercise?
Explain: _____

- YES___ NO___ 18 Do you have asthma? If so do you use an inhaler?
Explain: _____
- YES___ NO___ 19 Have you ever been informed that you have epilepsy or any abnormality of the circulatory system or brain?
Explain: _____
- YES___ NO___ 20 Have you ever experienced a seizure or convulsions?
Explain: _____
- YES___ NO___ 21 Do you have diabetes? If so What type and do you wear a pump or take insulin injections?
Explain: _____
- YES___ NO___ 22 Have you ever had a head injury or concussion? (please supply date(s) of injury)
Explain: _____
- YES___ NO___ 23 Have you ever been knocked out, lost consciousness, or lost your memory? (please supply times and dates)
Explain: _____
- YES___ NO___ 24 Do you have frequent or severe headaches?
Explain: _____
- YES___ NO___ 25 Have you had numbness or tingling in your arms, hands, legs, or feet?
Explain: _____
- YES___ NO___ 26 Have you ever had a stinger, burner, or pinched nerve?
Explain: _____
- YES___ NO___ 27 Have you had any injury to the neck involving nerves, vertebrae, or discs that incapacitated you for a week or more?
Explain: _____
- YES___ NO___ 28 Have you fractured, dislocated sprained or strained any of the following areas? If yes, please explain:

_____	_____	_____	_____	_____
Head	Chest	Elbow	Hand	Thigh
_____	_____	_____	_____	_____
Neck	Shoulder	Forearm	Hip	Lower Leg
_____	_____	_____	_____	_____
Back	Upper Arm	Wrist	Knee	Foot/Ankle

Explain: _____

- Have you ever been advised to have surgery to correct a shoulder, hip, knee or ankle condition? If so, what was the injury and surgery date?
YES___ NO___ 29
Explain: _____
- YES___ NO___ 30 Do you have a pin, screw, or plate somewhere in your body as a result of bone or joint surgery?
Explain: _____
- YES___ NO___ 31 Have you ever had a bone graft or spinal fusion?
Explain: _____
- YES___ NO___ 32 Have you ever had any problems with you eyes or vision? If so do you wear glasses, contacts or protective eye gear?
Explain: _____
- YES___ NO___ 33 Do you wear any dental appliances? If yes, please list.
Explain: _____
- YES___ NO___ 34 Do you have any dead teeth? If yes, please indicate approximate location.
Explain: _____
- YES___ NO___ 35 Have you ever had any problems with your hearing? If so do you wear a hearing device?
Explain: _____

Release to Treat:

By signing below, I hereby authorize the Athletic Training Staff, Team Physicians, School Nurses, Medical Consultants and Athletic Staff to have access to information and to provide any and all care deemed necessary for any specific injury or condition and to release any medical or insurance information necessary. By signing below, I hereby authorize the above parties to release and share any necessary information needed to treat a specific injury or condition, whether pre-existing or acute.

Student Signature _____ Date _____

Parent Signature _____ Date _____

Please return to Jessica Judge, ATC prior to the high school athletic season.