** **

**Name: (Last, First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_ Sport(s**)\_\_\_\_\_\_\_\_\_\_\_

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History Yes No**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
2. Do you have an ongoing medical condition (i.e. diabetes or asthma)?  
3. Are you taking any prescription or non-prescription (over the counter) medicines or pills?  
4. Do you have allergies to medicines, pollens, foods, or stinging insects?  
5. Have you ever passed out or nearly passed out DURING exercise?  
6. Have you ever passed out or nearly passed out AFTER exercise?  
7. Have you ever had discomfort, pain, or pressure, in your chest during exercise?  
8. Does your heart race or skip beats during exercise?  
9. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur,  

a heart infection?

10. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)?  

11. Has anyone in your family ever died for no apparent reason?  

12. Does anyone in your family have a heart problem?  

13. Has any family member or relative died of heart problems or of sudden death before age 50?  

14. Does anyone on your family have Marfan syndrome?  

15. Have you ever spent the night in a hospital?  

16. Have you ever had surgery?  

17. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  

18. Do you regularly use a brace or assistive device?  

19. Has a doctor ever told you that you have asthma or allergies?  

20. Do you cough wheeze, or have difficulty breathing during or after exercise?  

21. Is there anyone in your family that has asthma?  

22. Have you ever used an inhaler or taken asthma medicine?  

23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  

24. Have you had infectious mononucleosis (mono) within the last month?  

25. Do you have rashes, pressure sores, or other skin problems?  

26. Have you had a herpes skin infection?  

27. Have you ever had a head injury or concussion? If yes how many?\_\_\_\_\_\_\_  

28. Have you been hit in the head and been confused or lost your memory?  

29. Have you ever had a seizure?  

30. Do you have headaches with exercise?  

31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  

32. Have you ever been unable to move your arms or legs after being hit or falling?  

33. When exercising in the heat, do you have sever muscle cramps or become ill?  

34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?  

35. Have you had any problems with your eyes or vision?  

36. Do you wear protective eyewear, such as goggles or a face shield?  

37. Are you happy with your weight?  

38. Are you trying to gain or lose weight?  

39. Has anyone recommended you change your weight or eating habits?  

40. Do you limit or carefully control what you eat?  

41. Do you have any concerns that you would like to discuss with a doctor?  

**Circle below if you:**

42. Have you ever had an injury like a sprain, muscle or ligament tear that caused you to miss a practice or game?  

43. Have you have had any broken or fractured bones or dislocated joints?  

44. Have had a bone or joint injury that required x-ray, MRI, CT, surgery, injection, or physical therapy?  

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand/Fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes |

**Females Only Yes No**

42. Have you ever had a menstrual period?  

43. How old were you when you had your first menstrual period?\_\_\_\_\_\_

44. How many periods have you had in the last 12 months?\_\_\_\_\_\_

**Explain all “YES” answers (by number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***PHYSICIAN USE ONLY***

**DOB**\_\_\_\_\_\_\_\_\_\_ **Age\_\_\_\_\_\_\_ Height**\_\_\_\_\_\_ **Weight\_\_\_\_\_\_ Pulse**\_\_\_\_\_\_ **BP \_\_\_\_\_\_\_\_\_\_**

**Vision R 20/**\_\_\_ **L 20/**\_\_\_ **Corrected: Y N**\_\_\_/\_\_\_(\_\_\_/\_\_\_,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Sport(s)\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_ **Pupils: Equal\_\_\_\_\_\_ Unequal\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal Findings | Initials |
| Medical |  |  |  |
| Appearance |  |  |  |
| Eyes/ears/nose/throat |  |  |  |
| Hearing |  |  |  |
| Lymph nodes |  |  |  |
| Heart |  |  |  |
| Murmurs |  |  |  |
| Pulses |  |  |  |
| Lungs |  |  |  |
| Abdomen |  |  |  |
| Skin |  |  |  |
| Genitourinary (males only) |  |  |  |
| Musculoskeletal |  |  |  |
| Neck |  |  |  |
| Scoliosis Screen |  |  |  |
| Shoulder/arm |  |  |  |
| Elbow/forearm |  |  |  |
| Wrist/hand/fingers |  |  |  |
| Hip/thigh |  |  |  |
| Knee |  |  |  |
| Leg/ankle |  |  |  |
| Foot/toes |  |  |  |

**** **Cleared without restriction**

** NOT cleared for All sports Certain sports:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommendations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I hereby certify that I am qualified by training and experience to properly perform the examination**

**and make the evaluation reflected on this form**

**Name of physician (print/type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, MD, DO, DC, or RPA (Please circle)**

**** ****

**Intercollegiate Sports Medical Release**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_

Alternate phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned person, give my consent and authorize Niagara County Community College and Niagara Falls Memorial Medical Center to release medical information in their possession to the following individuals:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that I do not have to sign this authorization. Please initial here if you decline. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**** ****

**Intercollegiate Sports Medical Authorization for minors**

**(to be filled out by parent or guardian)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to athlete:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned person, give my consent and authorize Niagara County Community College and all its representatives as well as Niagara Falls Memorial Medical Center and its representatives to seek medical attention for the following individual:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to medical attention that has already been received. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that I do not have to sign this authorization. Please initial here if you decline. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

# Intercollegiate Sports Health History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## In case of emergency, contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### EXPLAIN ALL YES ANSWERS ON BACK

**Circle questions you do not know the answers to** YES NO

1. Has your doctor ever denied or restricted your participation in sports for any reason? \_\_\_\_ \_\_\_\_

Have you had a medical illness or injury since your last check up or sports physical? \_\_\_\_ \_\_\_\_

Do you have an ongoing or chronic illness? \_\_\_\_ \_\_\_\_

2. Have you ever been hospitalized overnight? \_\_\_\_ \_\_\_\_

Have you had surgery? \_\_\_\_ \_\_\_\_

3. Are you currently taking any prescription or non prescription (over the counter)

medications or pills or using an inhaler? \_\_\_\_ \_\_\_\_

Have you ever taken any supplements or vitamins to help you gain or lose weight or

improve your performance? \_\_\_\_ \_\_\_\_

4. Do you have any allergies to medicines, food, pollen or stinging insects? \_\_\_\_ \_\_\_\_

Have you ever had a rash or hives develop during or after exercise? \_\_\_\_ \_\_\_\_

5. Have you ever passed out during or after exercise? \_\_\_\_ \_\_\_\_

Have you ever been dizzy during or after exercise? \_\_\_\_ \_\_\_\_

Have you ever had chest pain during or after exercise? \_\_\_\_ \_\_\_\_

Have you ever had your heart race or skip beats during exercise? \_\_\_\_ \_\_\_\_

Have you ever been told you have a heart murmur? \_\_\_\_ \_\_\_\_

Has any family member or relative died of heart problems or of sudden death before age 50? \_\_\_\_ \_\_\_\_

Have you had a severe viral infection (for example, myocarditis or mononucleosis)

within the last month? \_\_\_\_ \_\_\_\_

Has your health care provider ever denied or restricted your participation in sports for

any reason? \_\_\_\_ \_\_\_\_

6. Have you ever had a head injury or concussion? \_\_\_\_ \_\_\_\_

Have you ever been knocked out, become unconscious, or lost memory? \_\_\_\_ \_\_\_\_

Have you ever had a seizure? \_\_\_\_ \_\_\_\_

Do you have frequent or severe headaches? \_\_\_\_ \_\_\_\_

Have you ever had numbness or tingling in your arms, hands, legs or feet after being hit

or falling? \_\_\_\_ \_\_\_\_

Have you ever had a stinger, burner or pinched nerve? \_\_\_\_ \_\_\_\_

7. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus

or blisters)? \_\_\_\_ \_\_\_\_

8. When exercising in the heat, do you have severe muscle cramps or become ill? \_\_\_\_ \_\_\_\_

9. Has a doctor told you or someone in your family they have sickle cell trait or disease? \_\_\_\_ \_\_\_\_

Do you cough, wheeze or have trouble breathing during or after activity? \_\_\_\_ \_\_\_\_

Do you or anyone in your family have asthma? \_\_\_\_ \_\_\_\_

Have you ever used an inhaler or taken asthma medicine? \_\_\_\_ \_\_\_\_

Do you have seasonal allergies that require medical treatment? \_\_\_\_ \_\_\_\_

10. Do you use any special protective or corrective equipment or devices that aren’t

usually used for your sport or position (for example, knee brace, foot orthotics,

retainer on your teeth, hearing aid)? \_\_\_\_ \_\_\_\_

11. Have you had any problems with your eyes or vision? \_\_\_\_ \_\_\_\_

Do you wear glasses, contacts or protective eyewear (goggles or face shield)? \_\_\_\_ \_\_\_\_

12. Are you happy with your current weight? \_\_\_\_ \_\_\_\_

Are you trying to gain or lose weight? \_\_\_\_ \_\_\_\_

Do you lose weight regularly to meet the requirements of your sport? \_\_\_\_ \_\_\_\_

13. Have you ever had a sprain, strain or swelling after an injury? \_\_\_\_ \_\_\_\_

Have you ever broken or fractured any bones or dislocated any joints? \_\_\_\_ \_\_\_\_

Have you had any other problems with pain or swelling in muscles, tendons,

bones or joints? \_\_\_\_ \_\_\_\_

***If yes, check appropriate line below:***

\_\_\_\_Head \_\_\_\_Elbow \_\_\_\_Hip

\_\_\_\_Neck \_\_\_\_Forearm \_\_\_\_Thigh

\_\_\_\_Back \_\_\_\_Wrist \_\_\_\_Knee

\_\_\_\_Chest \_\_\_\_Hand \_\_\_\_Shin/calf

\_\_\_\_Shoulder \_\_\_\_Finger \_\_\_\_Ankle

\_\_\_\_Upper arm \_\_\_\_Foot

**FEMALES ONLY:**

14. At what age was your first menstrual period? \_\_\_\_\_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_\_\_\_

How many periods have you had in the last year? \_\_\_\_\_\_\_\_\_

**EXPLAIN ALL “YES” ANSWERS HERE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

**Signature of Athlete\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**