

ACADEMY OF THE HOLY CROSS
4920 STRATHMORE AVENUE
KENSINGTON MD 20895

ATHLETIC MEDICAL HISTORY
QUESTIONNAIRE

School Year: _____

				Grade: 9 10 11 12 (circle one)
_____ Last Name	_____ First Name	_____ MI	_____/_____/_____ D.O.B.	_____ Sport (s)
_____ Street Address		_____ City	_____ State	_____ Zip
PARENTS(s)/GUARDIAN:				
Mother: _____		Father: _____		
Telephone Home: _____		Telephone Home: _____		
Work: _____		Work: _____		
Cell: _____		Cell: _____		
STUDEN HEALTH INSURANCE PROVIDER		EMERGENCY CONTACT PERSON		
_____ Name of Company	_____ Telephone #	NAME: _____		
_____ Policy #	_____ Group #	Telephone # H: _____		
		Telephone # W: _____		
		Telephone # C: _____		

- | | | | | | |
|---|------------|-----------|--|------------|-----------|
| <u>1. Has anyone in your close family ever had:</u> | YES | NO | <u>4. Have you had or do you now have:</u> | YES | NO |
| Diabetes? | 0 | 0 | Infectious Diseases? What? _____ | 0 | 0 |
| Allergies? | 0 | 0 | Pneumonia? | 0 | 0 |
| Asthma? | 0 | 0 | Mononucleosis? | 0 | 0 |
| Migraine Headaches? | 0 | 0 | Hepatitis? | 0 | 0 |
| Heart Condition? | 0 | 0 | HIV or AIDS? | 0 | 0 |
| High Blood Pressure? | 0 | 0 | Athlete's Foot? | 0 | 0 |
| Convulsions or Epilepsy? | 0 | 0 | Ringworm? | 0 | 0 |
| | | | Fungus Infection(s)? | 0 | 0 |
| <u>2. Have you had or do you now have:</u> | | | Recurrent rash or hives? | 0 | 0 |
| Brain Concussion (head injury)? | 0 | 0 | Recurrent Boils or Lesions? | 0 | 0 |
| Tendency to lose consciousness? | 0 | 0 | Seasonal Allergies (Hay Fever)? | 0 | 0 |
| Skull Fracture? | 0 | 0 | | | |
| Convulsions or Epilepsy? | 0 | 0 | <u>5. Do you fatigue easily or quickly with exercise?</u> | 0 | 0 |
| Neck Injury? | 0 | 0 | | | |
| Burners or Stingers or pinched nerve? | 0 | 0 | <u>6. Have you ever fainted during or after exercise?</u> | 0 | 0 |
| Numbness of Neck, Shoulders, or Hands? | 0 | 0 | | | |
| Temporary loss of vision? | 0 | 0 | <u>7. Do you frequently suffer from shortness of breath?</u> | 0 | 0 |
| Impaired Vision in one eye? Both Eyes? | 0 | 0 | | | |
| Hearing Loss? | 0 | 0 | <u>8. Do you frequently have problems with Hyperventilating?</u> | 0 | 0 |
| Perforated Ear Drum? | 0 | 0 | | | |
| Recurrent Ear Infections? | 0 | 0 | <u>9. Do you frequently suffer from chest pains during or after exercise?</u> | 0 | 0 |
| Discharge From Ear? | 0 | 0 | | | |
| Sinus Infections? | 0 | 0 | <u>10. Have you ever experienced skipped heartbeats or racing heart during or after exercise?</u> | 0 | 0 |
| Fracture/Broken Nose? | 0 | 0 | | | |
| Dentures? | 0 | 0 | <u>11. Have you ever been told by a physician that you have a heart murmur?</u> | 0 | 0 |
| Orthodontia (teeth straightened)? | 0 | 0 | | | |
| | | | <u>12. Have you ever been told you have <i>only one</i> or the absence of one of two functioning organs? (i.e. Kidney, eye, testicle, ovary)</u> | 0 | 0 |
| <u>3. Have you had or do you now have:</u> | | | Specify _____ | | |
| High Blood Pressure or cholesterol? | 0 | 0 | | | |
| Heart condition? | 0 | 0 | | | |
| Diabetes? | 0 | 0 | | | |
| Tendency to bruise or bleed easily? | 0 | 0 | | | |
| Anemia? | 0 | 0 | | | |
| Kidney Problems? | 0 | 0 | | | |
| Blood in urine? | 0 | 0 | | | |
| Hernia? | 0 | 0 | | | |
| Migraine Headaches? | 0 | 0 | | | |
| Persistent Cough? | 0 | 0 | | | |
| Asthma? | 0 | 0 | | | |

YES NO

13. Orthopedic Questions

Have you ever had a sprain, strain or swelling after injury? 0 0

Have you broken or fractured any bones or dislocated any joints? 0 0

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? 0 0

Have you had any surgeries in the past two years (explain below)? 0 0

Check the appropriate box for yes answers to the above questions and explain below.

- Head Upper Arm Wrist Hip Shin/Calf
- Neck Shoulder Hand Thigh Ankle
- Back Elbow Finger Knee Foot
- Chest Forearm

Explain YES answer here: _____

14. Do you TAKE MEDICATIONS(s) REGULARLY? 0 0

If YES, please name: _____

15. Do you TAKE MEDICATIONS(s) for EMERGENCY USE? 0 0

If YES, please name: _____

16. Are you ALLERGIC TO any MEDICATIONS(s)? 0 0

Name Medication(s) _____

17. Are you ALLERGIC TO INSECT BITES(s)? 0 0

Specify: _____

18. Have you had any injuries since your last physical for participation in athletics? 0 0

If YES, please explain:

19. Have you ever had any problems or episodes of Heat Illness, Dehydrations, Heat Exhaustion or Heat Stroke? If YES, please describe and give date. 0 0

20. Have you ever had or been told you have a head injury / concussion? 0 0

IF YES, Please answer the following.

A. Was it necessary to be evacuated to a hospital emergency room? 0 0

B. Did you see your family physician for this injury? 0 0

C. How long were you held from activity, sports, and competition? _____

D. What symptoms did you experience? (please circle all that apply)

- Headache Dizziness Nausea Vomiting Blurred Vision
- Poor Balance Confusion Irritability Neck Pain Memory Problems
- Sadness Nervousness Trouble Sleeping Sensitivity to Light Sensitivity to Noise
- Difficulty Concentrating

21. Have you had any illness requiring a physician's services since your last physical for participation in athletics? 0 0

If YES, please describe and give date.

22. Have you been advised by a physician NOT to participate in any activity within the last 12 months? 0 0

If YES, please describe and give date.

23. Please note any other medical conditions the Athletic Training staff should be aware of:

NAME: _____ D.O.B. ____/____/____ GRADE: _____ SPORT: _____

Height: _____	BP: _____	% Body Fat: _____ (optional)
Weight: _____	Pulse: _____	Flexibility: _____ (optional)
Vision: R 20/ _____	L 20/ _____	(N/A WITH WITHOUT - Glasses/Contacts)

Normal	Abnormal Finding	Initial*
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Normal	Abnormal Finding	Initial*
GENERAL MEDICAL		
General Appearance		
Skin		
Nose		
Throat		
Lymph Nodes		
Ears		
Chest		
Heart		
Lungs		
Abdomen		
Hernias		
Other		

NEUROLOGICAL		
DTRs		

Normal	Abnormal Finding	Initial*
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Normal	Abnormal Finding	Initial*
MUSCULOSKELETAL		
Spine (Neck/Back)		
Shoulders		
Arms		
Hands/Wrists		
Elbow		
Hips		
Legs		
Knees		
Ankles		
Feet		
Other		

Sensory		
Other		

*Station-based examination only.

CLEARANCE -----

CLEARED

Cleared AFTER completing evaluation /rehabilitation for: _____

NOT CLEARED for: _____ Reason: _____

Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the students medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities. (Note exceptions above)	
_____ Physicians Name & Address (stamp or print) If the Physician's Assistant (P.A.) or Advance Nurse Practitioner (A.P.N.) performed the exam, Name & Address of collaborating physician or physician group	_____ Examiners Signature _____ DATE
_____ 	_____ Examiner's Telephone Number
NOTE: History & Consent must be Completed Prior to Physical Examination	

Name: _____ Sport(s): _____ GRADE: 9 10 11 12

BY SIGNING BELOW, I/WE CERTIFY THAT:

I. Parental Consent to Treat:

- A. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainers, Staff, and Coaches to proceed with any necessary Primary and Secondary First Aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant is given.
- B. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainers to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation of injuries for the above-named student/athlete.
- C. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainers to proceed with any necessary use of modalities (i.e. Ice, Moist Heat, Ultrasound, Electric Stimulation, T.E.N.S, Light Therapy, Parafin Bath, Compression Unit, and Whirlpools) for the care, treatment and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the orders of The Academy of the Holy Cross Team physician and will only be administered by The Academy of the Holy Cross Certified Athletic Trainers.

II. Consent to Receive Medication:

Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer to distribute medication (listed below) to the above-named student/athlete. Please indicate if your daughter SHOULD NOT have any of the following medications that are available in the Athletic Training Room for athletes.

Bacitracin	New Skin Liquid Bandage
Biofreeze (analgesic)	Sterile Saline Solution
Betadine Solution (Providone - Iodine 10%)	Tinactic Athletes Foot Cream/Spray/Powder
Flexall (analgesic)	Tuffskin (Adherent Spray)
Gold Bond Powder	Zinc Oxide Ointment
Hydrogen Peroxide	
Hydrocortisone Cream 1.0%, 2.0%, 2.5%	

The above-named student should NOT take, is allergic to the following: _____

III. STATEMENT OF RISK:

I acknowledge that The Academy of the Holy Cross assumes no responsibility for any risks associated with voluntary participation in school organized athletic, physical education or other activities. Furthermore, I understand that these sports activities involve risk of serious injury or death. After weighing these risks against the potential benefits my daughter may gain from these activities, I freely and fully accept the risks or athletics on my child's behalf.

IV. STATEMENT OF LIABILITY: In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse, or my child, against The Academy of the Holy Cross and its employees arising from a sports related injury or from transportation to/from a sporting event.

V. STATEMENT CONCERNING TRANSPORTATION:

I understand when The Academy of the Holy Cross does not provide bus or van transportation; my child will be responsible for arranging her own means. I do not hold The Academy of the Holy Cross or its faculty or staff responsible for any problems that may arise from these personal arrangements.

By signing below I/we certify that: I/we are in agreement with the statements made above, the answers to the questions are true and correct and that I/we understand that having passed the physical examination does not necessarily mean that my child is physically qualified to engage in athletics but only that the examiner did not find medical reason to disqualify her at the time of said examination.

PARENT / GUARDIAN SIGNATURE

DATE

Name of Parent / Guardian (Print)

Relation to Athlete

