

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: _____		NAME: _____		
_____ Name of Company	_____ Telephone Number	Telephone # Home: _____		
_____ Policy Number		Telephone # Work: _____		
_____ Group Number		Telephone # Cell: _____		

This section is to be carefully completed by the student parent(s) or legal guardian.

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

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.

- | | | | | | |
|-------------------------------|------------------------------------|---------------------------------|--------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hip | <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle | <input type="checkbox"/> Forearm |
| <input type="checkbox"/> Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot | |

Explain YES answer here: _____

Medications

14. Do you TAKE MEDICATIONS(s) REGULARLY? If YES, please name: _____ 0 0

15. Do you TAKE MEDICATIONS(s) for EMERGENCY USE? If YES, please name: _____ 0 0

16. Are you ALLERGIC TO any MEDICATIONS(s)? Name Medication(s): _____ 0 0

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

18. Have you had any injuries since your last physical for participation in athletics?
If YES, please explain: 0 0

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

Head & Neck Injuries

20. Have you ever had a head injury or concussion (Mild Brain Injury)? 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 | | | | |

E. Do you have impaired vision in: ___LEFT EYE ___RIGHT EYE 0 0

F. Have you ever had a neck injury? 0 0

G. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? 0 0

H. Have you ever been unable to move your arms or legs after being hit or falling? 0 0

21. Have you had any illness requiring a physician's services since your last physical for participation in athletics?
If YES, please describe and give date. 0 0

22. Have you been advised by a physician NOT to participate in any activity within the last 12 months?
If YES, please describe and give date. 0 0

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

NAME: _____ D.O.B. ____/____/____ GRADE: _____ DATE OF PHYSICAL: _____

Does the child have a health condition that may require EMERGENCY ACTION while she is at school or athletic activities?
(e.g. seizure, asthma, heart problem, insect sting allergy, other) YES ____ NO ____

If YES please describe: _____

Is the child on regular medication? YES ____ NO ____ Name of medication(s): _____

Height: ____ ft ____ in	Blood Pressure: _____	Weight: ____ lbs	Respirations: _____	Pulse: _____
Vision: R 20/____ L 20/____ (N/A WITH WITHOUT – Glasses/Contacts)				

Date of most recent Tetanus _____

Date of 3rd Hepatitis B _____

Date of 2nd MMR _____

Date of Varicella/Disease _____

GENERAL MEDICAL	WNL	ABNORMAL	MUSCULOSKELETAL	WNL	ABNORMAL
General Appearance			Spine (Neck/Back)		
Skin			Shoulders		
Nose			Arms		
Throat			Hands/Wrists		
Lymph Nodes			Elbow		
Ears			Hips		
Chest			Legs		
Heart			Knees		
Lungs			Ankles		
Abdomen			Feet		
Hernias			Other		
NEUROLOGICAL			Sensory		
DTRs			Other		

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)

Physician's Name & Address (stamp or print)

Physician's Signature

Date of Exam

Telephone Number

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 _____

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.

Name of Parent / Guardian (Print)

PARENT / GUARDIAN SIGNATURE

DATE

Relation to Athlete