HISTORY QUESTIONNAIRE

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

1. Your Family’s Medical History

   Diabetes? __ Yes __ No
   Allergies? __ Yes __ No
   Asthma? __ Yes __ No
   Migraine Headaches? __ Yes __ No
   Heart Condition? __ Yes __ No
   High Blood Pressure? __ Yes __ No
   Convulsions or Epilepsy? __ Yes __ No

2. Have you had or do you now have:

   Brain Concussion (head injury)? __ Yes __ No
   Tendency to lose consciousness? __ Yes __ No
   Skull Fracture? __ Yes __ No
   Convulsions or Epilepsy? __ Yes __ No
   Burners or Stingers or Pinched Nerve? __ Yes __ No
   Numbness of Neck, Shoulders or Hands? __ Yes __ No
   Temporary loss of vision? __ Yes __ No
   Impaired vision in one eye? Both eyes? __ Yes __ No
   Hearing loss? __ Yes __ No
   Perforated Ear Drum? __ Yes __ No
   Recurrent Ear Infections? __ Yes __ No
   Discharge From Ear? __ Yes __ No
   Sinus Infections? __ Yes __ No
   Fracture/Broken Nose? __ Yes __ No
   Dentures? __ Yes __ No
   Orthodontia (teeth straightened)? __ Yes __ No
   Glasses/Contacts? __ Yes __ No

3. Have you had or do you now have:

   Asthma? __ Yes __ No
   Anemia? __ Yes __ No
   Behavioral or Emotional Problem? __ Yes __ No
   Birth Defects? __ Yes __ No
   Blood in Urine? __ Yes __ No
   Bowel Problems? __ Yes __ No
   Cerebral Palsy? __ Yes __ No
   Diabetes? __ Yes __ No
   Heart Condition? __ Yes __ No
   Hernia? __ Yes __ No
   High Blood Pressure or Cholesterol? __ Yes __ No
   Hospitalization? __ Yes __ No
   Where/When? __ Yes __ No
   Kidney Problems? __ Yes __ No

4. Have you had or do you now have:

   Infectious Diseases? __ Yes __ No
   Pneumonia? __ Yes __ No
   Mononucleosis? __ Yes __ No
   HIV or AIDS? __ Yes __ No
   Athlete’s Foot? __ Yes __ No
   Ringworm? __ Yes __ No
   Fungus Infection(s)? __ Yes __ No
   Recurrent Rash or Hives? __ Yes __ No
   Recurrent Boils or Lesions? __ Yes __ No
   Seasonal Allergies (Hay Fever)? __ Yes __ No
   Meningitis? __ Yes __ No

5. Do you fatigue easily or quickly with exercise? __ Yes __ No

6. Have you ever fainted during or after exercise? __ Yes __ No

7. Do you frequently suffer from shortness of breath? __ Yes __ No

8. Do you frequently have problems with hyperventilation? __ Yes __ No

9. Do you frequently suffer from chest pains during or after exercise? __ Yes __ No

10. Have you ever experienced skipped heartbeats or racing heart during or after exercise? __ Yes __ No

11. Have you ever been told by a physician that you have a heart murmur? __ Yes __ No

12. Have you ever been told you have only one or the absence of one of two function organs? __ Yes __ No

(i.e. kidney, eye, ovary, lung, ear) Specify:

Student Name: ____________________________

Physical Evaluation Form

Please print ____________________________

First Last

The Academy of the Holy Cross

Sponsored by the Sisters of the Holy Cross

4920 Strathmore Avenue Kensington, MD 20895 (301) 942-2100 www.ahctartans.org
Physical Evaluation Form

Student Name: __________________________

Please print

Last Name: __________________________
First Name: __________________________

ORTHOPEDIC QUESTIONS
13. Have you ever had a sprain, strain or swelling after injury? __ Yes ___ No
14. Have you broken or fractured any bones or dislocated any joints? __ Yes ___ No
15. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? __ Yes ___ No
16. Have you had any surgeries in the past two years (explain below)? __ Yes ___ No

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

<table>
<thead>
<tr>
<th>Head</th>
<th>Upper Arm</th>
<th>Wrist</th>
<th>Hip</th>
<th>Shin/Calf</th>
<th>Chest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>Shoulder</td>
<td>Hand</td>
<td>Thigh</td>
<td>Ankle</td>
<td>Forearm</td>
</tr>
<tr>
<td>Back</td>
<td>Elbow</td>
<td>Finger</td>
<td>Knee</td>
<td>Foot</td>
<td></td>
</tr>
</tbody>
</table>

Explain YES answers here:

MEDICATIONS
17. Do you take medication(s) regularly? If YES, please name: ____________________________ __ Yes ___ No
18. Do you take medication(s) for emergency use? If YES, please name: ____________________________ __ Yes ___ No
19. Are you allergic to any medication(s)? If YES, please name: ____________________________ __ Yes ___ No
20. Are you allergic to insect bites? If YES, please specify: ____________________________ __ Yes ___ No

21. Have you had any injuries since your last physical for participation in athletics? __ Yes ___ No
If YES, please explain:

22. Have you ever had any problems or episodes of Heat Illness, Dehydrations, Heat Exhaustion or Heat Stroke? __ Yes ___ No
If YES, please describe and give date.

HEAD & NECK INJURIES
23. Have you ever had a head injury or concussion (Mild Brain Injury)? __ Yes ___ No
If YES, Please answer the following:

A. Was it necessary to be evacuated to a hospital emergency room? __ Yes ___ No
B. Did you see your family physician for this injury? __ Yes ___ No
C. How long were you held from activity, sports, and competition? Please specify: ____________________________
D. Which symptoms did you experience? (Please check all that apply)

<table>
<thead>
<tr>
<th>Headache</th>
<th>Dizziness</th>
<th>Nausea</th>
<th>Vomiting</th>
<th>Blurred Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Balance</td>
<td>Confusion</td>
<td>Irritability</td>
<td>Neck Pain</td>
<td>Memory Problems</td>
</tr>
<tr>
<td>Sadness</td>
<td>Nervousness</td>
<td>Trouble Sleeping</td>
<td>Sensitivity to Light</td>
<td>Sensitivity to Noise</td>
</tr>
<tr>
<td>Difficulty Concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. Do you have impaired vision? Which eye? ___ left ___ right __ Yes ___ No
25. Have you ever had a neck injury? __ Yes ___ No
26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? __ Yes ___ No
27. Have you ever been unable to move your arms or legs after being hit or falling? __ Yes ___ No
28. Have you had any illness requiring a physician’s services since your last physical? __ Yes ___ No
If YES, please describe and give date:

29. Have you been advised by a physician NOT to participate in any activity within the last 12 months? __ Yes ___ No
If YES, please describe and give date:

30. Please note any other medical conditions the Health Center/Athletic Training staff should be aware of:

If you would like to further discuss your child’s health with the school or school health personnel, please check all that apply:

___ Nurse ___ Teacher ___ Counselor ___ Principal ___ Athletic Trainer

4920 Strathmore Avenue  Kensington, MD 20895  (301) 942-2100  www.ahctartans.org
PHYSICAL EXAMINATION
(This page to be completed by physician/nurse practitioner/physician assistant)

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

1. Does the child have a diagnosed medical condition? YES ___ NO ___
   If YES please describe:_____________________________________________________________________________________

2. 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, bleeding problem, diabetes, other) YES ____ NO ___
   If YES please describe: ___________________________________________________________________________________

3. Is the child on regular medication? YES ____ NO ___ Name of medication(s): _________________________________

4. Is this child on long term technology assistance? YES ____ NO ___

Tuberculin test: Results □ Positive □ Negative _____ (Type) ______ Date (most recent)
Immunizations given on this visit: _______________ Date of most recent TETANUS immunization: _____________

Height: _____ ft _____ in  Blood Pressure: _______ Weight: _____ lbs  Respirations: _______ Pulse: _______

Vision: R 20/______ L 20/______ (N/A WITH WITHOUT – Glasses/Contacts)

<table>
<thead>
<tr>
<th>GENERAL MEDICAL</th>
<th>WNL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>WNL</td>
<td>ABNORMAL</td>
</tr>
<tr>
<td>Spine (Neck/Back)</td>
<td>WNL</td>
<td>ABNORMAL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
<th>WNL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulders</td>
<td>WNL</td>
<td>ABNORMAL</td>
</tr>
<tr>
<td>Elbow</td>
<td>WNL</td>
<td>ABNORMAL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
<th>WNL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory</td>
<td>WNL</td>
<td>ABNORMAL</td>
</tr>
</tbody>
</table>

○ CLEARED FOR ALL PHYSICAL ACTIVITY

○ NOT CLEARED → Reason: ____________________________________________

Note, should the above named athlete have any restrictions, a letter from the individual’s physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. The AHC Certified Athletic Trainers and administrators reserve the right to make the final decision as to the above named athlete’s status regarding participation in interscholastic athletics for The Academy of the Holy Cross high school.

I certify that I have on this date above 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

4920 Strathmore Avenue  Kensington, MD  20895  (301) 942-2100  www.ahctartans.org
MEDICAL RELEASE AND PERMISSION TO TREAT

Student Name: _______________________  Sport(s): ___________________________  Grade: __ 9 __10 __11 __12

BY SIGNING BELOW, I CERTIFY THAT:

I. PARENTAL CONSENT TO TREAT:
   A. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer, 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 Trainer 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 Trainer to proceed with any necessary use of modalities (i.e. Ice, Moist Heat, Ultrasound, and Electric Stimulation) for the care, treatment, and rehabilitation for the above-named student/athlete’s injury(s) administered by The Academy of the Holy Cross Certified Athletic Trainer.

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.

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

The above-named student should NOT take/is allergic to the following: ____________________________

III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION:
I hereby authorize the Athletic Training Staff to use and disclose our daughter’s medical information for purposes related to the evaluation, care, and treatment of athletic-related injuries. I understand that I may revoke this authorization at any time; however, the revocation will not apply to information that has already been released in the response to this authorization. Should I choose to revoke this authorization, I must do so in writing and present my written revocation to the Athletic Training Staff. Unless otherwise revoked, this authorization will be in effect for the entire school year and tryout periods.

IV. 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 of athletics on my child’s behalf.

V. 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.

VI. 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 certify that I am in agreement with the statements made above, the answers to the questions are true and correct, and that I 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