The Preuss School UCSD

HISTORY FORM

Grade: _____

Date of Birth: _____

Please Print Clearly

STUDENT ATHLETE'S LAST NAME | STUDENT ATHLETE'S FIRST NAME | MI

PARENT'S MEDICAL STATEMENT AND EMERGENCY INFORMATION

FATHER'S WORK PHONE: (____) _____
FATHER'S CELL PHONE OR PAGER: (____) _____
MOTHER'S WORK PHONE: (____) _____
MOTHER'S CELL PHONE OR PAGER: (____) _____
FAMILY DOCTOR: _____
DR. PHONE: (____) _____
EMERGENCY CONTACT NAME: _____
RELATIONSHIP: _____
EMERGENCY CONTACT PHONE: (____) _____
CELL PHONE OR PAGER: (____) _____

Family Medical Insurance: _____
Member ID #: _____
Insurance Company: _____
HMO or PPO - (circle one) Group #: _____

Medications *(Over the counter and prescribed)*: _____
Allergies *(Food and Drug)*: _____
Known Health Risks *(High Blood Pressure, Asthma, Anemic, ect...)*: _____
SPORTS PLAYED: _____

Brief Medical History:

Please answer the following questions regarding you son/daughter/ward:

1. Has had injuries requiring medical attention. Yes | No
2. Has had an illness requiring hospitalization. Yes | No
3. Is under physician's care at this time. Yes | No
4. Has had coughing, wheezing, or trouble breathing during or after activity. Yes | No
5. Has had asthma. Yes | No
6. Has had seasonal allergies that require medical treatment. Yes | No
7. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes | No
8. Have you ever passed out during or after exercise? Yes | No
9. Have you ever been dizzy during or after exercise? Yes | No
10. Have you ever had chest pain during or after exercise? Yes | No
11. Do you get more tired quickly than your friends do during exercise? Yes | No
12. Have you ever had racing of your heart or skipped heartbeats? Yes | No
13. Have you ever been told that you have a heart murmur? Yes | No
14. Has any family member or relative died of heart problems or of sudden death before age 55? Yes | No
15. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes | No
16. Has a physician ever denied or restricted your participation in sports? Yes | No
17. Have you ever had a head injury or concussion? Yes | No
18. Have you ever been knocked out, become unconscious, or lost your memory? Yes | No
19. Have you ever had a seizure? Yes | No
20. Do you have frequent or severe headaches? Yes | No
21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes | No
22. Have you ever had a stinger, burner, or pinched nerve? Yes | No
23. Have you ever become ill or felt light headed from exercising in the heat? Yes | No
24. Is hearing impaired, has glasses / contact lenses. Yes | No
25. Has fixed or removable appliances in mouth. Yes | No
26. Is there a reason for this individual to avoid participation in a certain sport? Yes | No

Please explain if yes response: _____

FEMALES ONLY

Have you ever had a menstrual period? Yes | No
How old were you when you have your first menstrual period? ____
How many periods have you had in the last 12 months? _____
Explain "Yes" answer here: _____

Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____

In case of injury, I hereby give consent for my son/daughter to have initial first aid administered by school personnel in charge and to be transported to a doctor or hospital for further treatment if necessary.

X _____

Parent Signature

This section to be completed by a physician or nurse practitioner.

Student's Name: _____

Review of Medical History:

Pertinent past medical history: _____

Current medical disorders: _____

Physical Exam:

BP _____ HEIGHT _____ WEIGHT _____ VISION _____

HR _____

NEUROLOGICAL _____ HEAD/NECK _____ CHEST/AIRWAY _____

GENITALIA/HERNIAS _____ MUSCULOSKELETAL _____ STRENGTH _____

Description of abnormalities above: _____

_____

_____

Recommendations:

_____ There are no restrictions or special considerations to participation in the high school athletic program.

_____ The following are limitations or special considerations: _____

_____

_____ This student should be restricted from participating in high level contact sports with post-pubertal males at this time.

_____ This student is disqualified from sports until further evaluation.

Physician or Nurse Practitioner statement/signature:

I, the undersigned, am licensed to elicit and interpret the medical history, pharmaceutical history, and clinical findings of a complete health assessment for participation in an athletic program. I have completed this assessment and recorded all pertinent findings above.

X _____ _____

Physician, DO or Nurse Practitioner Signature | Date of Exam

_____ _____

Printed Name | Address

_____

License Number

Notes: