2017 Junior Sports Camp
ATHLETE HEALTH HISTORY

Date: _____

NAME (last, first) _____ DOB _____ AGE _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Gender: Male Female (Circle one)

EMERGENCY CONTACT:

1. Name/Relationship _____ Phone_____Cell_____
2. Name/Relationship _____ Phone_____Cell_____

INSURANCE INFORMATION:

Insurance Company _____ Policy Number _____

Dental Insurance Company _____ Policy Number _____

DIAGNOSIS/DISABILITY: _____

ALLERGIES (be specific): Medications _____

Environmental/food/other _____Latex (yes/no) ____

What are your symptoms from an allergic reaction? _____

CURRENT MEDICATIONS & DOSAGE*:* (attach separate page if necessary)

_____

PAST SURGERIES*:* _____

Do you have a shunt in place? Y N (circle one)

Have you ever had a shunt malfunction? Y N (circle one)

If yes, what were the symptoms? _____

Have you ever had a tethered spinal cord? Y N (circle one)

If yes, what were the symptoms? _____

Have you ever been knocked out or had a concussion? Y N (circle one)

If yes, describe the incident: _____

Do you have any history of seizures? Y N (circle one)

If yes, what type, and how are they managed? _____

Do you have diabetes? Y N (circle one)

If yes, how is it managed? _____

Do you have a history of heart disease, heart murmurs, or high blood pressure? Y N (circle one)

Has anybody in your family had a sudden death or heart attack before 50 years? Y N (circle one)

Have you ever been dizzy or passed out with exercise? Y N (circle one)

Have you ever had any fractures, sprains, or strains (F=fracture, S=strain or sprain)?

Neck _____ Arm _____ Hip _____ Back _____ Hand _____ Thigh _____

Elbow _____ Knee _____ Fingers ____ Shoulders _____ Wrist_____

Do you have scoliosis? Y N (circle one)

Have you had a back fusion? Y N (circle one)

Do you have any organs missing? Y N (circle one)

Specify: _____

Do you wear/use: glasses, contact lenses, hearing aides, dental appliances, orthotics, prosthetics,

What type of bladder management do you use? (check all that apply)

Do you use disposable undergarments? Y N (circle one)

None _____ Indwelling catheter _____ Intermittent catheter _____

Other (specify) _____

Have you had any recent (last 3 months) bladder infections? Y N (circle one)

Do you have any problems with constipation or loose stools? Y N (circle one)

Do you have any history of pressure ulcers requiring surgery? Y N (circle one)

Do you have any current pressure sores? Y N (circle one)

Where are they and how are you treating them? _____

_____

Do you use a wheelchair or assistive device? Y N (circle one)

Please circle all that apply: manual/ power assistive device for ambulating

What type of wheelchair cushion do you use? _____

Do you have any chronic illnesses? Y N (circle one & and specify) _____

Date of last tetanus shot: _____

Are your other immunizations up-to-date? Y N (circle one & if no, why) _____

How many hours per week do you train? _____

What sports do you participate in? _____

Do you have any problems with (check all that apply)?

Overheating _____ Dysreflexia _____ Spasticity _____ Pain _____

Are any of the problems made worse by exercise? Y N (circle one & and specify)_____

Are any of the problems made better by exercise? Y N (circle one & and specify) _____

Do you have or have had any of the following medical/health problems? [IF YES, PLEASE SPECIFY]:

High Blood Pressure	_____No	_____Yes	_____
Asthma	_____No	_____Yes	_____
Heart Disease	_____No	_____Yes	_____
Other	_____No	_____Yes	_____

Please enclose any pertinent health/medical information from your physician

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian if person is under age 18 Date

2017 Junior Sports Camp

ATHLETE MEDICAL FORM
(Must be completed by a Licensed Physician, Physician Assistant, or Nurse Practitioner)

NAME: _____ AGE: _____ CLASS: _____ SEX: ____

ADDRESS: _____

SPORTS: _____

FAMILY PHYSICIAN: _____ PHONE: _____

HT: _____ WT: _____ BP: _____

General:

Region Examined	Satisfactory			Comments
	Yes	No	Not Examined	
Eyes				
ENT				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Ortho				
Neuro				
Flex/Strength				

Follow-up recommendations: _____

Sports Participation approved: Yes ___ No ___ Restricted _____

Limitations: _____

Physician's Signature: _____ Date: _____

Physician Name (please print) _____ Physician Phone #: _____