# MEDICAL HISTORY EVALUATION

**PART I: INFORMATION** *(To be filled out by parent or guardian only)*

Name:_____Grade:_____School: Home School Saints, New Orleans, LA

Sex: M / F Age:_____Date of Birth:_____Home Telephone #:_____Sports:_____

Social Security Number:_____Address:_____City:_____Zip:_____

Parent's Name:_____Parent's Employer:_____Work Telephone #:_____

Insurance Company:_____Policy #:_____Family Doctor:_____

**PART II: MEDICAL HISTORY** *(To be filled out by parent or guardian)*

**Has or Does this athlete** **Circle & please explain all "yes" answers below**

| | | | |
|---|---|---|---|
| 1. | Have a medical problem or injury since his/her last evaluation? | YES | NO |
| | Ever not been allowed to participate in sports for a medical reason? | YES | NO |
| 2. | Ever been hospitalized? | YES | NO |
| | Ever had surgery? | YES | NO |
| | Have any missing organs? *(eye, kidney, testicle, etc.)* | YES | NO |
| 3. | Presently take any medication? | YES | NO |
| 4. | Have any allergies to medicine or insect bites? | YES | NO |
| 5. | Passed out during or after exercise? | YES | NO |
| | Been dizzy or passed out during or after exercise? | YES | NO |
| | Have chest pain during or after exercise? | YES | NO |
| | Tire more quickly than his/her friends during exercise? | YES | NO |
| | Have high blood pressure? | YES | NO |
| | Been told he/she has a heart murmur? | YES | NO |
| | Have racing of the heart or skipped heartbeats? | YES | NO |
| | Have a family member that died of heart problems or sudden death before age 50? | YES | NO |
| 6. | Have any skin problems? | YES | NO |
| 7. | Ever had a head or neck injury? | YES | NO |
| | Ever been knocked out or unconscious? | YES | NO |
| | Ever had a seizure? | YES | NO |
| | Ever had a stinger, burner or pinched nerve? | YES | NO |
| 8. | Ever had heat cramps? | YES | NO |
| | Ever been dizzy or passed out in the heat? | YES | NO |
| 9. | Have trouble with breathing or coughing during or after activity? | YES | NO |
| 10. | Use any special equipment? *(pads, braces, neck rolls, eye guards, kidney belt, etc.)* | YES | NO |
| 11. | Have any problems with vision? | YES | NO |
| | Wear glasses or contacts? | YES | NO |
| 12. | Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? | YES | NO |

13, Have any medical problems listed below? *(Please check off)*

_____High Blood Pressure _____Rheumatic Fever _____Diabetes _____Hepatitis

_____Mononucleosis _____Abnormal Bleeding _____Tuberculosis _____Asthma

_____Sickle Cell Disease/Trait _____Other*(list)* _____

14. List dates for last: Tetanus Shot:_____Measles Immunization:_____

15. Female athletes, list dates for: First menstrual period:_____Last menstrual period:_____

Longest time between periods last year:_____

Please explain all "yes" answers from above:_____

_____

_____

## PART III: SIGNATURES

*(You must answer these questions and sign for your child to be examined)*

1. The information on the reverse is current and correct to the best of my knowledge ..... YES NO
2. I give my permission for my child to be examined for school-related activities ..... YES NO
3. If, in the judgment of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary..... YES NO
4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed..... YES NO
5. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately ..... YES NO
6. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school. ..... YES NO

Signature of Parent/Guardian:_____Date:_____

Signature of Student Athlete:_____Date:_____

**PART IV: PHYSICAL** *(To be filled out by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)*

| | | | | | |
|---|---|---|---|---|---|
| | LIMITED | **Height** | **Weight** | **Blood Pressure** / | **Pulse** |
| | | SYSTEM | NORMAL | ABNORMAL | INITIALS | COMMENTS |
| | | Heart | | | | |
| | | Lung | | | | |
| | | Other | | | | |
| COMPLETE | | Abdominal | | | | |
| | | Genitalia | | | | |
| | | Neck | | | | |
| | | Shoulder | | | | |
| | | Elbow | | | | |
| | | Wrist | | | | |
| | | Hand | | | | |
| | | Back | | | | |
| | | Knee | | | | |
| | | Ankle | | | | |
| | | Foot | | | | |
| | | Eye | Right 20/ | Left 20/ | Corrected? YES / NO | |

**CLEARANCE**: _____A. Cleared

_____B. Cleared after further evaluation/treatment

_____C. Not cleared for: _____Collision _____Contact _____Non-contact

**RECOMMENDATIONS:**_____

_____

**NAME OF MD/NURSE PRACTITIONER:**_____**DATE:**_____

**ADDRESS:**_____**TELEPHONE:**_____

**SIGNATURE OF MD/NURSE PRACTITIONER:**_____