Amity Regional School District #5

1st Period_____
Grade_____

Medical History Questionniare

(please print)

NAME____DATE____________________

ADDRESS____
street city state zip

HOME PHONE_____________________DOB______________ HT_______WT_______ B/P________________

VARSITY SPORT(S):1.________________________________2.________________________________

I. MEDICAL HISTORY

Please check the following boxes yes or no.

	YES	NO
1. Do you have any known allergies?	☐	☐
• If yes, please indicate type(s):		
• Medications, foods____		
• Bee sting reaction	☐	☐
2. Are you currently on any long-term continuous medications?	☐	☐
• If yes, what type:____		
3. Have you ever had a concussion? If yes, how many?	☐	☐
4. Do you have a seizure disorder (epilepsy) or have you ever seized?	☐	☐
5. Have you ever lost consciousness when exposed to heat or had a heat related illness?	☐	☐
6. Is your vision in one or both eyes worse than 20/50 ***with*** glasses?	☐	☐
7. Do you wear glasses or contact lenses during sports participation?	☐	☐
8. Have you had a retinal detachment or serious eye injury?	☐	☐
9. Do you have significant hearing loss in one or both ears?	☐	☐
10. Do you have ear tubes or a perforated eardrum?	☐	☐
11. Do you wear any dental appliances (braces, false teeth)?	☐	☐
12. Have you ever sustained a nasal fracture?	☐	☐
13. Have you ever had recurrent pneumonias?	☐	☐
14. Do you have asthma or do you wheeze with exercise?	☐	☐
15. Do you have high blood pressure or high cholesterol?	☐	☐
16. Do you have a heart problem or been limited from sports because of a heart problem?	☐	☐
17. Have you ever fainted or nearly fainted with strenuous exercise?	☐	☐
18. Have you ever had heart palpitations, chest pain or difficulty breathing with exercise?	☐	☐
19. Do you have recurrent diarrhea?	☐	☐
20. Are you on a specific diet (i.e., vegetarian)?	☐	☐
21. Have you over the past five years lost more than 10 pounds in one year?	☐	☐
22. Do you or have you ever had an eating disorder?	☐	☐
23. Do you have a liver disease?	☐	☐
24. Do you have only one kidney?	☐	☐
25. Do you have a kidney disease?	☐	☐
26. Do you have an undescended or absent testicle (if applicable)?	☐	☐
27. Do you have diabetes?	☐	☐
28. Do you have an endocrine abnormality (thyroid, adrenal)?	☐	☐
29. Do you have a bleeding disorder or have you ever been anemic?	☐	☐
30. Do you have a chronic skin problem/rash?	☐	☐
31. Have you ever or do you currently have any form of cancer?	☐	☐
32. Have you ever had a severe viral infection causing you to miss more than a month of school?	☐	☐
33. Have you ever had a neck or spine injury or a stress fracture of the back?	☐	☐
34. Do you get recurrent low back pain?	☐	☐
35. Have you ever had a pinched nerve ("burner')? If yes, how often?________________________	☐	☐

36. Did you receive the hepatitis vaccination? ☐ ☐
37. Did you receive the influenza vaccination? ☐ ☐
38. Please carefully list below any musculoskeletal injuries that you have sustained, in your athletic career, which restricted your participation in regular activity for a week or more. ☐ ☐

Injured Area	Diagnosis (fracture, sprain, strain, dislocation, overuse, etc.)	Side R/L/ NA	Year(s)	Resolved Yes	No
☐ Shoulder					
☐ Elbow					
☐ Wrist					
☐ Hand					
☐ Hip					
☐ Knee					
☐ Ankle					
☐ Foot					
☐ Muscle/tendon					
☐ Bone					
☐ Other					

39. For female participants: YES NO
   - Have you *not* begun your menstrual periods? ☐ ☐
   - Do you have disabling cramps with your menstrual periods? ☐ ☐
   - Have you ever gone regularly 3 months or more without menstrual periods? ☐ ☐
40. Has any family member died suddenly at less than 40 years of age of causes other than an accident? ☐ ☐
   - What was the cause?
41. Does any family member have Marfan's syndrome? ☐ ☐
42. Does any family member have a chronic health condition? ☐ ☐
   - If yes please explain.______________________________
43. Has any family members had a heart attack at less than 55 years of age? ☐ ☐
44. Were you ever hospitalized for medical or surgical reasons including one-day surgery? ☐ ☐
45. Please indicate:

Hospital:__________________Year:______Reason:_________________________

Hospital:__________________Year:______Reason:_________________________

46. Do you have any other medical problems or issues you would like to discuss with the team physician? ☐ ☐

I, hereby state that to the best of my knowledge, my answers to the above questions are correct and I give my permission for my child to have a physical performed by the school physician (**Parents/Student: Please Note - This physical is valid only for Amity interscholastic Athletics.)

Parent's Signature__________________________Student's Signature________________________________Date__________

II. PHYSICIAN'S STATEMENT

Please circle appropriate permission for participation and include specific training requirements.

A. This student can participate in a full intercollegiate athletic program with the exception of the following sports:______________________________
B. This student should have the following health problems evaluated or treated before participation recommendations can be made:______________________________
C. This student should not participate in:______________________________
D. Recommendations:______________________________

Physician's Signature____Date______________