
**QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)**

Athlete’s Name \_ \_ Male \_ Female Date of Birth Grade \_

Home Address \_ \_

Phone # \_ \_

Parent’s/Guardian’s Name \_ \_

Date

Family Physician \_ \_

Phone #

**HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)**

**Yes No Does this student have / ever had?**

 1. \_ \_ Allergies to medication, pollen, stinging

insects, food, etc.?

 2. \_ \_ Any illness lasting more than one (1) week?

 3. \_ \_ Asthma or difficulty breathing during exercise?

 4. \_ \_ Chronic or recurrent illness or injury?

 5. \_ \_ Diabetes?

 6. \_ \_ Epilepsy or other seizures?

 7. \_ \_ Eyeglasses or contacts?

 8. \_ \_ Herpes or MRSA?

 9. \_ \_ Hospitalizations (Overnight or longer)?

 10. \_ \_ Marfan Syndrome?

 11. \_ \_ Missing organ (eye, kidney, testicle)?

 12. \_ \_ Mononucleosis or Rheumatic fever?

 13. \_ \_ Seizures or frequent headaches?

 14. \_ \_ Surgery?

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15. \_ \_ Chest pressure, pain, or tightness with exercise?

16. \_ \_ Excessive shortness of breath with exercise?

17. \_ \_ Headaches, dizziness or fainting during, or after, exercise?

18. \_ \_ Heart problems (Racing, skipped beats,

murmur, infection, etc.?)

19. \_ \_ High blood pressure or high cholesterol?

**Yes No Family History:**

**Yes No Does this student have / ever had?**

20. \_ \_ Head injury, concussion, unconsciousness?

21. \_ \_ Headache, memory loss, or confusion with contact?

22. \_ \_ Numbness, tingling or weakness in arms or

legs with contact?

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23. \_ \_ Severe muscle cramps or illness when

exercising in the heat?

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24. \_ \_ Fracture, stress fracture or dislocated

joint(s)?

25. \_ \_ Injuries requiring medical treatment?

26. \_ \_ Knee injury or surgery?

27. \_ \_ Neck injury?

28. \_ \_ Orthotics, braces, protective equipment?

29. \_ \_ Other serious joint injury?

30. \_ \_ Painful bulge or hernia in the groin area?

31. \_ \_ X-rays, MRI, CT scan, physical therapy?

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**32. \_ \_ Has a doctor ever denied or restricted your participation in sports for any**

**reason?**

**33. \_ \_ Do you have any concerns you would like to discuss with your health care**

**provider?**

 34. \_ \_ Does anyone in your family have Marfan syndrome?

 35. \_ \_ Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?

 36. \_ \_ Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?

 37. \_ \_ Has anyone in your family had unexplained fainting, seizures, or near drowning?

 38. \_ \_ Does anyone your family have asthma?

Use this space to explain any **“YES”** answers from above (questions #1-35) or **to provide any additional information**: (please continue on back if you need more space)

\_\_

 39. Are you allergic to any prescription or over-the-counter medications? If yes, list:

 40. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:

 A. \_ \_ \_ B. \_ \_ C.

 41. Year of last known vaccination: Tetanus: \_ Meningitis:

Influenza:

 42. What is the most and least you have weighed in the past year? **Most**  \_ **Least**  \_

 43. Are you happy with your current weight? **Yes**  \_\_ **No**  **If no**, how many pounds would you like to lose or gain?

Lose \_ \_ Gain

**PARENT’S OR GUARDIAN’S PERMISSION AND RELEASE**

 I hereby **verify** the accuracy of the information provided on this form and **give my consent** for the above named student-athlete to engage in approved athletic activities as a representative of his/her trainer or coach, except those activities indicated by a licensed medical professional. Any activities deemed unsafe for student-athlete must be made known to trainer or coach by licensed medical professional via written note or health record. I also **give my**

**permission** for the team’s physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic

event in case of injury.

 \_ \_ \_ \_ Name of Parent or Guardian (Printed) Signature of Parent of Guardian

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Address (Street/PO Box, City, State, Zip) Phone Number

This form has been developed with the assistance of the Committee on Sports Medicine of the Massachusetts Medical Society .