

**2008 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

**2008 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 #: \_\_\_\_\_