Athletic Medical History and Clearance Form 2009-10

Emmanuel College Athletic Department
400 The Fenway • Boston, MA 02115 • 617-735-9847

STUDENT-ATHLETE INFORMATION

Name: ______________________________ SSN: ______________________ DOB: ____________
Permanent Address: ________________________ City: _____________ ST: _________ Zip _________
Home Phone Number: (___) ____________________ Cell Phone Number: (___) ______________________
Primary Care Physician __________________________ Physician Phone Number (___) ____________
Emergency Contact _____________________________ Emergency Contact # (___) ______________
Sport Team(s) ____

A. Please circle and explain any injury and provide approximate dates. (More space on back)

	Yes	No	Date
1. Neck injury (stingers, burners, disc injury):____________________	_	_	______
2. Shoulder/Elbow (separation, dislocation, fracture):____________________	_	_	______
3. Wrist/Hand (fracture):____________________	_	_	______
5. Hip/Thigh (sacroiliac, Femur):____________________	_	_	______
6. Upper/Lower Back (disc herniation, spondilolysis): ____________________	_	_	______
7. Knee (patella pain, ligament sprain, meniscus):____________________	_	_	______
8. Lower Leg (fracture, stress fracture): ____________________	_	_	______
9. Ankle (sprain, dislocation, fracture): ____________________	_	_	______
10. Foot (sprain, fracture): ____________________	_	_	______

B. Please list and date any overnight hospital stay or surgeries. IF OCCURRED WITHIN THE PAST YEAR PLEASE SEND DOCMUMENTATION OF CLEARANCE FOR ATHLETIC PARTICIPATION

1. Date _________ Procedure ____

____

2. Date _________ Procedure ____

____

C. Please date and explain all "Yes" answers.

	Yes	No	Date
1. Have you ever had a head injury?____________________	_	_	______
2. Have you ever had a seizure? If yes, date of last seizure and any medications taken____________	_	_	______
____			
3. Do you experience chronic or severe headaches? ____________________	_	_	______
4. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ____________________	_	_	______
____			
5. Do you take any prescription or over the counter medications regularly? (please list)____________	_	_	______
____			
6. Do you have any severe allergies to food or insect bites?____________________	_	_	______
7. Do you have seasonal allergies or allergies that require medications? ____________________	_	_	______
8. Do you have asthma? If yes, please list any medications or inhalers used. ____________________	_	_	______
____			
9. Do you have any current skin conditions (athletes foot, ring worm)?____________________	_	_	______
10. Have you ever had a herpes skin infection? ____________________	_	_	______
11. Have you ever passed out during physical activity? ____________________	_	_	______
12. Have you ever had chest pain during or after activity? ____________________	_	_	______
13. Have you ever had heart palpitations at rest or with activity?____________________	_	_	______
14. Have you ever been diagnosed with a heart murmur? ____________________	_	_	______
15. Do you have a family history or heart problems before age 50? ____________________	_	_	______

C. Please date and explain all "Yes" answers. (Cont) **Yes No Date**

16. Have you had a severe viral infection (mono, myocarditis) within the past 6 months?__________ _ _ ______
____
17. Have you been restricted from sports due to heart problems? ______________________________ _ _ ______
18. Do you have a family history of Marfan's Syndrome, Cardiomyopathy, or long QT syndrome?___ _ _ ______
____
19. Have you ever become sick from exercising in the heat? ____________________________________ _ _ ______
20. Do you use any special protective/assistive equipment?(knee brace, hearing aid, orthotics, _ _ ______
retainers, etc...)? ____
21. Have you ever had any severe eye trauma? ____ _ _ ______
22. Is your vision in either eye less than 20/40 even with correction (glasses/contacts), or have you ever _ _ ______
had any other eye trauma? ____
23. Do you have any feelings of significant stress or depression? ___________________________________ _ _ ______
If yes, are you taking any medications? (please list)____
24. Have you ever had an eating disorder (aneorexia, bulimia)?______________________________________ _ _ ______
25. Have you ever had/have a weight problem? ____ _ _ ______
26. Please list and describe any medical problems not mentioned on this form: ___________________________
____
____

Females Only

27. How old were you when you had your first menstrual period? ______________________________________
28. How much time do you usually have from the start of one period to the start of the next? ________________
29. How many periods have you had in the last year? ____
30. What is the longest time between periods in the last year? _______________________________________
31. Do you use any type of oral/injection form of hormone or birth control medication? ____________________

All Participants I verify by my signature below that:

1. I understand that even a normal history and physical examination may not rule out the presence of potentially life threatening health problems.
2. I understand that I must abstain from athletic competition during medical treatment until I am given permission by the Children's Hospital Sports Medicine Team to resume participation.
3. I understand that even a report of having passed the physical examination does not necessarily mean that I am permitted to participate in athletics, but only that the physician did not find a medical reason to restrict me at the time of the examination.
4. All the information reported here and on the health insurance form is current and accurate.
5. I understand that Children's Hospital Division of Sports Medicine and the Emmanuel College Counseling and Health Services Department may need to communicate medical or mental health information to my athletic trainer, if my condition will affect my ability to compete in athletics. Information will be held to the minimum necessary to assist in the decision-making regarding my participation, athletic treatment and rehabilitation. I understand that I may revoke this consent at any time with the knowledge that my clearance to participate in any Emmanuel College athletic activity may be revoked. I also understand that while it is Emmanuel's practice to disclose such information only as appropriate in relation to my continued participation in athletics, disclosure by the recipient (e.g. to my coach and others as may be necessary or appropriate) is no longer protected under the medical privacy law (HIPPA).
6. I understand that although Emmanuel College and its medical care providers take precautions to safeguard my health and safety, serious and potentially debilitating injures can and do occur while participating in any activity. I know that it is extremely important that all student athletes and parents should consider thus consider and be ever mindful of the risks that are involved in such competition. I feel comfortable with and accept these risks that are associated with athletic practice and competition.

Participant Name (printed) ____
Signature of Participant: ______________________________ **Date** ______________
If Participant is under the age of 18 years old, Parental/Guardianship Signature is required.
Parent/Guardian Name (printed)____
Parent/Guardian Signature ______________________________ **Date** ______________