Appendix A

Western Carolina University
Athletic Training Department
First Year Medical History Form

Please return to:
WCU Athletic Training Department
WCU Athletics
Ramsey Center
Cullowhee, North Carolina 28723

Sport:______________

Please Read
Prior to your participation in Western Carolina University athletics, the following form must be completed and returned to the address listed above. Please read each section carefully and answer every question with as much detail as possible. Any form with questions left unanswered will be considered incomplete and will delay your participation. If you have any questions regarding this form, please contact the WCU athletic training department at (828) 227-2043.

Consent to Release Information

This is to authorize Western Carolina University athletic trainers, university physicians, and athletic coaches to release any medical information regarding my son, daughter, or myself, to various media outlets, concerning illness or injury relative to my past, present or future participation in athletics at WCU.

________________________________ ________________________________

Athletes Signature Date Parents Signature (if athlete is not 18) Date

____

Last Name First Name Middle Name

____

Date of Birth Social Security Number

____

Home Address City State Zip Code

(______)____________________ (______)____________________

Home Telephone Number School Telephone Number

__________________________ (______)____________________

Emergency Contact Name Telephone Number

__________________________ (______)____________________

Father's Name Work Telephone Number

__________________________ (______)____________________

Mother's Name Work Telephone Number

Have you ever been advised to restrict activity for any medical reason?______________________
____
____

Do You Wear Glasses or Contacts? Glasses_____________ Contacts____________

Are you allergic to any medication? Yes__________ No__________
If yes, please list:____
____
____

Family History:	Age	Health	Age at Death	Cause
Mother	______	______	_________________________	
Father	______	______	_________________________	
Siblings	______	______	_________________________	
Grandparents	______	______	_________________________	
	______	______	_________________________	
	______	______	_________________________	

Has any blood relative ever been diagnosed with any of the following?

Sudden Death age 50	______	High Blood Pressure	______
Cancer	______	Diabetes	______
Heart Disease	______	Stroke	______
Blood Disease (sickle cell, leukemia)	______	Epilepsy	______
Tuberculosis	______		

Other Comments:____
____
____
____
____
____

Female Athletes (Males skip to next section)

Age you experienced your first menstrual period			_______________________________
Any past pregnancies:	Yes	No	_______________________________
Are you taking birth control pills?	Yes	No	_______________________________
Date of your last menstrual period			_______________________________
History of Anemia	Yes	No	_______________________________
History of Eating Disorders	Yes	No	_______________________________
History of Osteoporosis	Yes	No	_______________________________
The longest time you've gone between periods			_______________________________
When was your last Gynecological Exam?			_______________________________

Have you ever had or do you currently have any of the following orthopedic injuries? Please check the appropriate lines and explain all injuries in detail at the bottom of the page (date, extent, etc…)

Head/Neck		**Arm**	
Concussion	______	Fracture	______

Pinched Nerve ______
Burners/Stingers ______
Fractures ______
Sprains/Strains ______
Disc Problems ______
Unexplained Pain ______
Surgery ______
Other: ______________________

Hands, Wrist, Fingers
Fracture ______
Sprain/Strain ______
Surgery ______
Other: ______________________

Shoulder/Clavicle
Fracture ______
Subluxation/Dislocation ______
Separation ______
Tendonitis ______
Impingement ______
Contusion ______
Other: ______________________

Pelvis/Hip
Fracture ______
Subluxation/Dislocation ______
Contusion/Hip Pointer ______
Groin Strain ______
Tendonitis ______
Surgery ______
Other: ______________________

Lower legs, Ankle, Feet
Fracture ______
Sprains/Strains ______
Shin Splints ______
Surgery ______
Do you wear orthotics? ______
Other: ______

Calcium Deposit ______
Ruptured Muscle ______
Other: ______________________

Elbow
Fracture ______
Subluxation/Dislocation ______
Sprain/Strain ______
Tendonitis ______
Surgery ______
Other: ______________________

Thigh
Quadriceps Strain ______
Hamstring Strain ______
Fracture ______
Ruptured Muscle ______
Calcium Deposits ______
Tendonitis ______
Other: ______________________

Knee
Fracture ______
Ligament Damage ______
Cartilage Damage/Removal ______
Subluxation/Dislocation ______
Contusion ______
Unexplained Pain ______
Tendonitis ______
Surgery ______
Other: ______________________

Explain:______________________
____
____
____
____
____
____

Have you or do you currently have any of the following? Check the appropriate line and explain in detail at the bottom of the page (date, extent, etc…).

High Blood Pressure ______
Frequent Headaches ______
Migraine Headaches ______
Fainting/Unconsciousness ______
Chronic Sore Throat ______

Frequent Skin Infection ______
Heat Exhaustion ______
Heat Stroke ______
Kidney/Bladder Infection ______
Thyroid Disease ______

Mononucleosis	______	Seizures Disorder	______
Heart Problems	______	Hepatitis	______
Rheumatic Fever	______	Hernia	______
Tuberculosis	______	Sickle Cell Anemia	______
Scarlet Fever	______	Diabetes	______
Appendicitis	______	Cancer, Tumor, Growth	______
Loss of a paired organ	______	Pneumonia	______
Emotional Problems	______	Frequent Concussion	______
Hernia	______		

Explain: ____
____
____
____

Do you currently have Asthma? Yes No

If you answered yes please list any medication that you are taking, the date of your last asthma attack: ____
____

Immunization History: Please insert the date of immunization in the appropriate line.

	Date
Diphtheria/Tetanus	______
MMR (2 immunizations required)	______/______
Tuberculin Skin Test	______

Please read and sign the following statement.

I certify that all of the above information is accurate and current, and hereby authorize the appropriate Western Carolina University personnel to provide or seek proper medical care in the event that I am injured or require medical treatment while participating in Western Carolina University Athletics.

______________________________ ______________________________

Signature Date Parent Signature (if athlete is not 18) Date

______________________________ ______________

Reviewing Certified Athletic Trainer Signature Date