

Appendix B
Western Carolina University
Athletic Training Department
Returnee 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 you will be delayed in 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
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Last Name	First Name	Middle Name
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Date of Birth	Social Security Number
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Home Address	City	State	Zip Code
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() _____
 Home Telephone Number

() _____
 School Telephone Number

 Emergency Contact Name

() _____
 Telephone Number

 Fathers Name

() _____
 Work Telephone

 Mothers Name

() _____
 Work Telephone

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

Concussion _____
 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: _____

Arm

Fracture _____
 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: _____

Do You Wear Glasses or Contacts? Glasses _____ Contacts _____

Are you allergic to any medication? Yes _____ No _____

If yes, please list: _____

Since last season has any blood relative 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: _____

Since last season have you experienced any of the following conditions?

High Blood Pressure	_____	Frequent Skin Infection	_____
Frequent Headaches	_____	Heat Exhaustion	_____
Migraine Headaches	_____	Heat Stroke	_____
Fainting/Unconsciousness	_____	Kidney/Bladder Infection	_____
Chronic Sore Throat	_____	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	_____

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: _____

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