

# LHSAA MEDICAL HISTORY EVALUATION

**IMPORTANT:** This form must be completed annually, kept on file with the school, and is subject to inspection by the LHSAA Rules Compliance Team.

## PART I: INFORMATION *(To be filled out by parent or guardian only)*

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Sex: M / F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Telephone #: \_\_\_\_\_ Sports: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Employer: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

## PART II: MEDICAL HISTORY *(To be filled out by parent or guardian)*

**Has or Does this athlete**

**Circle & please explain all "yes" answers below**

- |  |     |    |
|--|-----|----|
| 1. Have a medical problem or injury since his/her last evaluation? .....                                 | YES | NO |
| Ever not been allowed to participate in sports for a medical reason? .....                               | YES | NO |
| 2. Ever been hospitalized? .....   | YES | NO |
| Ever had surgery? .....  | YES | NO |
| Have any missing organs? ( <i>eye, kidney, testicle, etc.</i> ) .....                                    | YES | NO |
| 3. Presently take any medication? .....  | YES | NO |
| 4. Have any allergies to medicine or insect bites? .....   | YES | NO |
| 5. Passed out during or after exercise? .....  | YES | NO |
| Been dizzy or passed out during or after exercise? .....   | YES | NO |
| Have chest pain during or after exercise? .....  | YES | NO |
| Tire more quickly than his/her friends during exercise? .....  | YES | NO |
| Have high blood pressure? .....  | YES | NO |
| Been told he/she has a heart murmur? .....   | YES | NO |
| Have racing of the heart or skipped heartbeats? .....  | YES | NO |
| Have a family member that died of heart problems or sudden death before age 50? .....                    | YES | NO |
| 6. Have any skin problems? .....   | YES | NO |
| 7. Ever had a head or neck injury? .....   | YES | NO |
| Ever been knocked out or unconscious? .....  | YES | NO |
| Ever had a seizure? .....  | YES | NO |
| Ever had a stinger, burner or pinched nerve? .....   | YES | NO |
| 8. Ever had heat cramps? .....   | YES | NO |
| Ever been dizzy or passed out in the heat? .....   | YES | NO |
| 9. Have trouble with breathing or coughing during or after activity? .....                               | YES | NO |
| 10. Use any special equipment? ( <i>pads, braces, neck rolls, eye guards, kidney belt, etc.</i> ) .....  | YES | NO |
| 11. Have any problems with vision? .....   | YES | NO |
| Wear glasses or contacts? .....  | YES | NO |
| 12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? ..... | YES | NO |
| 13. Have any medical problems listed below? ( <i>Please check off</i> )                                  |     |    |

- |                                 |                                  |                    |                 |
|---------------------------------|----------------------------------|--------------------|-----------------|
| _____ High Blood Pressure       | _____ Rheumatic Fever            | _____ Diabetes     | _____ Hepatitis |
| _____ Mononucleosis             | _____ Abnormal Bleeding          | _____ Tuberculosis | _____ Asthma    |
| _____ Sickle Cell Disease/Trait | _____ Other( <i>list</i> ) _____ |                    |                 |

14. List dates for last: Tetanus Shot: \_\_\_\_\_ Measles Immunization: \_\_\_\_\_

15. Female athletes, list dates for: First menstrual period: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_

Longest time between periods last year: \_\_\_\_\_

Please explain all "yes" answers from above: \_\_\_\_\_

**PART III: SIGNATURES**

*(You must answer these questions and sign for your child to be examined)*

- |  |     |    |
|--|-----|----|
| 1. The information on the reverse is current and correct to the best of my knowledge .....   | YES | NO |
| 2. I give my permission for my child to be examined for school-related activities.....   | YES | NO |
| 3. If, in the judgment of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary ..... | YES | NO |
| 4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed .....                               | YES | NO |
| 5. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately.....  | YES | NO |
| 6. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school.....  | YES | NO |

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

**PART IV: PHYSICAL** *(To be filled out annually by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)*

C O M P L E T E	L I M I T E D	Height		Weight		Blood Pressure	/	Pulse	
		SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS			
		Heart							
	Lung								
	Other								
	Abdominal								
	Genitalia								
	Neck								
	Shoulder								
	Elbow								
	Wrist								
	Hand								
	Back								
Knee									
Ankle									
Foot									
Eye	Right	20/	Left	20/	Corrected?	YES	/	NO	

**CLEARANCE:** \_\_\_\_\_ A. Cleared  
 \_\_\_\_\_ B. Cleared after further evaluation/treatment  
 \_\_\_\_\_ C. Not cleared for: \_\_\_\_\_ Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-contact

**RECOMMENDATIONS:** \_\_\_\_\_

**NAME OF MD/NURSE PRACTITIONER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **TELEPHONE:** \_\_\_\_\_

**SIGNATURE OF MD/NURSE PRACTITIONER:** \_\_\_\_\_