LCSAA MEDICAL HISTORY EVALUATION

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? *(eye, kidney, testicle, etc.)*	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? *(pads, braces, neck rolls, eye guards, kidney belt, etc.)*	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? *(Please check off)*

_____High Blood Pressure _____Rheumatic Fever _____Diabetes _____Hepatitis

_____Mononucleosis _____Abnormal Bleeding _____Tuberculosis _____Asthma

_____Sickle Cell Disease/Trait _____Other*(list)* _____

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 by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.*)

		Height	**Weight**	**Blood Pressure** /	**Pulse**
		SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS
LIMITED		Heart				
		Lung				
		Other				
COMPLETE		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:_____