Purge Year ____________

Entered ☐

SPORTS MEDICINE

Sport(s): ______________________________

Athletic Participation Health Form

Name ______________________________ **S.S.#** ____________________
First   Middle Initial   Last

Local Address ______________________________
(Your St. Cloud State on/off campus address)

City ______________________ **State** __________ **Zip Code** __________

☐ **Male** ☐ **Female** **Birthdate** __________ **Telephone** __________ **Cell Phone** __________

GUARDIAN/Mother:

Name ______________________________
First   Middle Initial   Last

Address ______________________________
(Street)

Address ______________________________
(City)   (State)   (Zip Code)

Telephone ____________________ / ____________________
(Home)   (Work or Cell)

E-mail ______________________________

GUARDIAN/Father:

Name ______________________________
First   Middle Initial   Last

Address ______________________________
(Street)

Address ______________________________
(City)   (State)   (Zip Code)

Telephone ____________________ / ____________________
(Home)   (Work or Cell)

E-mail ______________________________

St. Cloud State University

MEDICAL HISTORY

To be completed **by the athlete** and reviewed by the physician. Please answer **ALL** questions and explain any **"yes"** questions in the space provided in each section.

General Medical History

Current Medications/Supplements: Prescription and over-the-counter.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Immunization: Most recent.

Tetanus: ____________________ (MM/DD/YYYY)

HBV: ____________________ (MM/DD/YYYY)

Hepatitis: ____________________ (MM/DD/YYYY)

MMR: ____________________ (MM/DD/YYYY)

Smallpox: ____________________ (MM/DD/YYYY)

Other: ____________________ (MM/DD/YYYY)

Family History: Has anyone in your immediate family had?

	YES	NO	Please Explain:
Sudden Death (Before 50)			
Heart Disease/Heart Attack			
Heart Murmur			
Abnormal Heart Rate/Palpitation			
High Blood Pressure/Hypertension			
Diabetes			
Marfan Syndrome			
Epilepsy			
Blood Disorder			

Personal Medical History: Have you ever had/currently have any of the following conditions?

	YES	NO
ADD/ADHD		
Anemia/Low Blood Counts		
Appendicitis		
Asthma/Breathing Problems		
If you have an inhaler please bring an extra to the athletic trainer		
Chicken Pox		
Diabetes		
Eating Disorder (anorexia, bulimia)		
Emotional Disturbance (Depression / Anxiety)		
Epilepsy/Seizure Disorder		
Hearing Impairment/Loss		
Hepatitis/Liver Problems/Jaundice		
Kidney Disease/Stones/Injury		

	YES	NO
Menstrual Irregularities		
Mononucleosis		
Pneumonia/Frequent Respiratory Infections		
Sickle Cell Disease		
Sickle Cell Trait		
Spleen/Liver Injury		
Stomach Problems (bleeding, ulcers)		
Stress Fracture		
Thyroid Disorder		
Tuberculosis		
Tumor/Growth/Cyst		
Urinary Problems (blood, recurrent infections)		
Human immunodeficiency virus (HIV)		
Herpes skin infection or cold sores		

Please Explain: ____________________
____
____

Internal/Surgical History:

	YES	NO
Were you born **WITHOUT** a complete set of organs (eyes, kidneys, ovaries/testes, etc…)?		
Have you ever had to repair / remove any organ (hernia, tonsils, appendix, spleen, etc…)?		

Please Explain: ____

Allergies:

	YES	NO
Aspirin/Anti-Inflammatories		
Codeine		
Hay Fever		
Insect Stings/Bites		
Latex		
Penicillin		

	YES	NO
Sulfa		
Any Foods		
Other		
If you have an epi-pen please bring an extra to the athletic trainer		

Please Explain: ____

Cardiac History: Have you ever had/currently have any of the following conditions?

	YES	NO
High blood pressure/Hypertension		
Irregular heart beat/Palpitations		
Felt dizzy/Light-headed/Passed out during or after exercise?		
Chest pain/Tightness/Discomfort with exercise?		
Exertional shortness of breath		

	YES	NO
Have seen a cardiologist?		
Rheumatic heart disease		
Had an echocardiogram/EKG?		
Had a stress test?		
Heart Murmur		
Easily fatigued		

Please Explain: ____

Heat Illness History: Have you ever?

	YES	NO
Become dehydrated?		
Had heat cramps?		
Had heat exhaustion?		

	YES	NO
Had heat stroke?		
Received IV fluids?		
Had intolerance to heat?		

Please Explain: ____

Vision History: Have you ever/do you currently:

	YES	NO
Had an eye injury?		
Wear glasses/contacts/protective eyewear?		

Please Explain: ____

Dental History: Have you ever/do you currently:

	YES	NO
Wear a dental appliance?		

Please Explain: ____

Please describe below any further general medical injury information, which is knowledgeable to you and has not been requested.

____

<u>Orthopedic History</u>

Head, Neck and Cervical Spine Injury: Have you ever had/currently have:

	YES	NO
Concussion**, please give dates below.**		
Knocked out/Unconscious		
Recurrent headaches/Migraines		
Fracture/dislocation		
Injury/Sprain/Strain		

	YES	NO
Disk Injury		
Numbness/tingling/burning in arms or legs		
Pinched nerve/stinger		
Hospitalization/Surgery		
Other		

Please Explain: ____

____

Shoulder/Upper Arm: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation/Subluxation		

	YES	NO
Shoulder Separation		
Numbness/Tingling/Burning		
Other		

Please Explain: ____

____

Elbow/Forearm: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation		

	YES	NO
Hospitalization/Surgery		
Numbness/Tingling/Burning		
Other		

Please Explain: ____

____

Wrist/Hand/Finger: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Brace/Cast/Splint		
Fracture/Dislocation		

	YES	NO
Hospitalization/Surgery		
Numbness/Tingling/Burning		
Other		

Please Explain: ____

____

Spine/Low Back: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Nerve/Disk Injury		
Numbness/Tingling/Burning in leg		

	YES	NO
Pain in leg		
Fracture/Dislocation		
Other		

Please Explain: ____

____

Ribs/Chest: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Fracture/Dislocation		
Hospitalization/Surgery		

	YES	NO
Numbness/Tingling/Burning		
Other		

Please Explain: ____

____

Hip/Groin: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation		
Hernia		

	YES	NO
Hospitalization/Surgery		
Numbness/Tingling/Burning		
Other		

Please Explain: ____

____

Thigh: Have you ever had/currently have:

	YES	NO
Numbness/Tingling/Burning		
Injury/Sprain/Strain		
Fracture		
Other		

Please Explain: ____

____

Knee: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation/Subluxation		
Torn cartilage/Meniscal injury		
Swelling		

	YES	NO
Locking/Giving away		
Numbness/Tingling/Burning		
Brace/Cast/Splint		
Surgery		
Other		

Please Explain: ____

____

Ankle/Lower Leg: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation		
Instability		
Stress Fracture/Shin Splints		
Numbness/Tingling/Burning		

	YES	NO
Brace/Cast/Splint		
Hospitalization/Surgery		
X-ray/CT/MRI/Bone Scan		
Missed practice/game time		
Other		

Please Explain: ____

____

Foot/Toe: Have you ever had/currently have:

	YES	NO
Injury/Sprain/Strain		
Bursitis/Tendinitis		
Fracture/Dislocation		
Unexplained weakness		

	YES	NO
Brace/Cast/Splint		
Numbness/Tingling/Burning		
Hospitalization/Surgery		
Other		

Please Explain: ____

____

Please describe below any further general medical injury information, which is knowledgeable to you and has not been requested.

____

____

____

____

____

____

____

I, ______________________________ , do hereby release the St. Cloud State University Sports Medicine Staff from
Student-Athlete Printed Name
all responsibility for any injury or consequences resulting from any information that I provided or ANY information that I failed to provide.

______________________________ Student-Athlete Signature

______________________________ Date

HEALTH EXAMINATION FORM

TO BE COMPLETED BY MEDICAL PHYSICIAN

Date (M/D/Yr) .... ______________________

Weight (pounds) .... ______________________

Height (inches).............................. ______________________

HEART

a. Pulse .... ______________________

b. Blood Pressure.................. ______________________

c. Auscultation .... ______________________

LUNGS .... ______________________

H.E.N.T .... ______________________

CARDIOVASCULAR

ABNORMALITIES.................... ______________________

VISION .... *R* _________ /_________

L _________ /_________

MUSCULOSKELETAL EVALUATION

a. Neck .... ______________________

b. Shoulder .... ______________________

c. Upper ext. .... ______________________

d. Trunk .... ______________________

e. Thigh .... ______________________

f. Knee.................................... ______________________

g. Ankle.................................. ______________________

NEUROLOGICAL .... ______________________

TETANUS & DIP.

Toxoids (M/D/Yr) .... ______________________

SICKLE CELL .... ______________________

COMMENTS

I hereby certify that ____

(Athlete's Name)

was examined by me. At that time no physical condition was detected which could reasonably be anticipated to render this athlete physically unfit to engage in any sport, except ____ . (If none state "none.")

____ MD or DO ___________________________

Signature of Examining Physician | Date

____ ___________________________

Clinic Name | Phone Number

____

Clinic Address | City | State | Zip

PS921