

# LHSAA MEDICAL HISTORY EVALUATION

**IMPORTANT:** This form must be 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: \_\_\_\_\_

Last 4 Digits of 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     |
|     | _____ Mononucleosis   | _____ Abnormal Bleeding          | _____ Tuberculosis |
|     | _____ Sickle Cell Disease/Trait   | _____ Other( <i>list</i> ) _____ | _____ Hepatitis    |
|     |   |                                  | _____ Asthma       |

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.)*

C O M P L E T E	L I M I T E D	<b>Height</b>		<b>Weight</b>		<b>Blood Pressure</b>		<b>Pulse</b>	
		<b>SYSTEM</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>INITIALS</b>		<b>COMMENTS</b>		
		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:** \_\_\_\_\_