

# 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>		
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Sickle Cell Disease/Trait	<input type="checkbox"/> 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:** \_\_\_\_\_