

Student-Athlete Name: _____ **Sport:** _____

Returning Athlete? **Freshman/Transfer?**

- This form must be completed in its entirety prior to the first practice or you will not be allowed to participate.
- The information contained in this form is protected under medical confidentiality guidelines and will be used as an aid to providing appropriate health care while you are a student-athlete at Johnson State College.
- Your knowledge and consent are required for release of any information contained in this medical record.

Completed forms must be returned to: Renee Breault, Head Athletic Trainer **or – FAX: 802-635-1497**
 Department of Athletics **ATTN: Renee Breault**
 Johnson State College
 337 College Hill
 Johnson, VT 05656

Personal Contact Information

Date of Birth: _____ **Telephone (home):** _____

Home Address: _____

(optional) – Do you or your family have any religious beliefs that would affect or restrict the medical assistance we provide for you if you become injured or ill while participating in athletics at Johnson State College?

Yes No

Please explain if possible

Father’s Name: _____ **Telephone:** _____ **same as above**

Address: _____ **same as above**

Mother’s Name: _____ **Telephone:** _____ **same as above**

Address: _____ **same as above**

Family Health History

Please indicate if any of your family has had any of the following:

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Allergies				Fainting			
Anemia				Heart Disease			
Arthritis				High Blood Pressure			
Asthma				Migraine Headache			
Cancer				Kidney Disease			
High Cholesterol				Intestinal Problems			
Depression				TB/Lung Disease			
Diabetes				Stomach Disease			
Epilepsy				Stroke			
Convulsions				Heart Attack < age 50			

Anything not listed above: Yes No

Please Explain any positive answers.

Personal Health History

Have you ever had or do you currently have:

	Yes	No		Yes	No		Yes	No
Anemia			Eating Problems			Sickle Cell Disease		
Arthritis			Fainting/Blackouts			Skin Trouble		
Asthma			Headaches (frequent)			Strep-throat (frequent)		
Chest Pain w/exercise			Headaches (migraine)			Tendency to bleed		
Colitis			Heart murmur			Tendency to bruise		
Convulsions			Hepatitis/Juandice			Tuberculosis		
Dental Bridges/Plates			Hernia			Tumor		
Depression			High Blood Pressure			Ulcer/Stomach or other		
Diabetes			Low Blood Pressure			Urinary Tract infection		
Dizziness w/exercise			Mononucleosis			Varicose Veins		
Ear trouble/hearing loss			Heart Palpitations			Vision Difficulties		
Gastrointestinal issues			Sinus infection (frequent)					

Others not listed? _____

Please explain any positive answers given above: _____

Do you wear contact lenses? Yes No **Do you wear glasses?** Yes No

Surgical History:

Please list, giving dates and explanations, any surgeries you have had: _____

Hospitalization History:

Please list, giving dates and explanations, any hospitalizations you have had: _____

Current Medications:

Are you currently taking any medications? Yes No

Please provide names and dosages for any medications you are taking: _____

Allergies: Please indicate if you have any of the following allergies:

- | | | | |
|-------------------|--------------------------|--------------------------|--|
| | Yes | No | |
| Environmental | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ice (Cold) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bees/Wasps | <input type="checkbox"/> | <input type="checkbox"/> | |
| Food | <input type="checkbox"/> | <input type="checkbox"/> | |
| Drugs/Medications | <input type="checkbox"/> | <input type="checkbox"/> | |

If yes, do you have/use a bee sting kit? Yes No

Please explain: _____

Please explain: _____

******* Women Only: Please indicate if you have any of the following *******

- | | | | |
|-------------------|------------|-----------|---|
| Irregular Periods | Yes | No | What was your age at menstrual onset? _____ |
| Severe Cramps | Yes | No | |
| Breast Lumps | Yes | No | |

Excessive menstrual flow **Yes** **No**

In the past year, what was the longest time between periods? _____

Do you know, or is there any possibility that you may be pregnant? _____

Do you currently have, or have you ever had, any of the following injuries that caused you to miss at least 1 game or practice, or required X-rays or other diagnostic imaging? This information will help us better care for your injuries (present and future). Please be honest and complete to the best of your ability.

A. Concussion (s) & / or Skull Fracture (s). Yes ___ No ___ When? _____

Explain _____

B. Neck Injuries (inc. burners/stingers). Yes ___ No ___ When? _____

Explain _____

C. Shoulder Injuries Yes ___ No ___ When? _____

Explain _____

D. Elbow Injuries Yes ___ No ___ When? _____

Explain _____

E. Wrist/Hand Injuries Yes ___ No ___ When? _____

Explain _____

F. Rib/Chest Injuries Yes ___ No ___ When? _____

Explain _____

G. Back/Spine Injuries Yes ___ No ___ When? _____

Explain _____

H. Hip/Thigh Injuries. Yes ___ No ___ When? _____

Explain _____

I. Knee/Lower Leg Injuries. Yes ___ No ___ When? _____

Explain _____

J. Foot/Ankle Injuries. Yes ___ No ___ When? _____

Explain _____

Any special equipment/padding/braces/devises needed to participate in intercollegiate athletics at JSC?

Explain _____

The undersigned, here with:

- 1) Understands that if I am removed from a practice or a game or willingly leave a practice or game due to an injury or illness, that I must have appropriate medical clearance before I can return to participation;
- 2) Grants permission to JSC athletic trainers, personnel, or physicians to secure necessary and appropriate emergency and non-emergency medical care;
- 3) Understands that having passed a physical examination does not necessarily mean that s/he is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him/her at the time of said physical examination;
- 4) Certifies that the answers to the above questions are true.

Student-Athletes Signature _____ sport _____ Date _____

Student-Athlete's Parent/Guardian Signature if under 18 years of age: _____

Student-Athlete Name: _____ **Date of Birth:** ____ / ____ / ____
 (last) (first) (m.i.)

Gender: M F **Date of Last Tetanus Booster:** ____ / ____ / ____ **Height:** ____ **Weight:** ____

Pulse: ____ bpm **Blood Pressure:** ____ / ____ mmHg **Visual Acuity:** L ____ R ____

Corrective Lenses? Yes No **Type:** Glasses Contacts Both

Are there any abnormalities of the following systems?

	Y	N	If "yes" please explain
Head, Ears, Nose, Throat, or Mouth			
Eyes			
Neck / Thyroid			
Respiratory / Lungs			
Cardiovascular / Heart			
Auscultations (supine & standing)			
Physical stigmata of Marfan's syndrome			
Gastrointestinal			
Hernia			
Abdomen			
Urogenital			
Skin / Integumentary			
Neurological			
Mental Status			

Musculoskeletal Examination: Any abnormalities (decrease ROM or strength, laxity) or current injury to:

	Y	N	If "yes" please explain
Neck			
Shoulders			
Elbows / Forearms			
Hands / Wrists			
Spine / Back			
Hips / Thighs			
Knees			
Ankles / Lower legs			
Feet			

Is there loss or seriously impaired function of any paired organ? **Yes** ___ **No** ___

Explain _____

Recommendation for Participation in Intercollegiate Athletics: **Unlimited** ___ **Limited** ___ **Prohibited** ___

If limited, is there any further information which would be helpful in meeting the health care needs of this student-athlete, or any special equipment / padding / brace / device required for participation? _____

I hereby certify that the above information is completed to the best of my knowledge.

Health Care Provide Name: _____ Phone() _____ Fax () _____
 (please print or stamp)

Address: _____

Health Care Provider Signature: _____ **Date:** _____