

Health Questionnaire and Physical Exam

Please return completed copy to: **Renee Breault, Department of Athletics, Johnson State College, SHAPE Facility, 337 College Hill, Johnson, VT 05656, or fax to 802-635-1497.**

- **This form must be completed, (all 4 pages), prior to the first practice or you will not be allowed to participate. THERE ARE NO EXCEPTIONS:**
- This information is strictly confidential and will be used as an aid to providing health care while you are a student-athlete at JSC.
- Your knowledge and consent will be required for release of this medical record. Please fill out this form completely and to the best of your knowledge.
- Do not skip any lines. Please check the appropriate "yes or no" box and fully explain any "yes" answers and give dates.
- Please also provide all insurance and emergency notification information (front/back of current insurance card).

PART A: to be completed by the student **PRIOR** to his/her visit with a Health Care Provider.

DATE: _____ **Sport (s):** _____

Name: _____ SS#: _____
 (last) (first) (m.i.)

Student's Home Address: _____
 (street) (city) (state,zip)

Birth date: ___/___/___ Gender: M F

Father's Name: _____ Telephone #: _____ Address: _____

Mother's Name: _____ Telephone #: _____ Address: _____

Medical Insurance Information:
**** Please Provide a front and back copy of your Health Insurance card.**

Emergency Notification:

Name: _____ Address: _____

Relationship: _____ Telephone: (H): _____ (W)/(C) _____

Family Medical History

	Y	N	Relationship		Y	N	Relationship
1. Allergies				11. Fainting			
2. Anemia				12. Heart Disease			
3. Arthritis				13. High Blood Pressure			
4. Asthma				14. Migraine Headache			
5. Cancer				15. Kidney Disease			
6. High Cholesterol				16. Intestinal Problems			
7. Depression				17. TB/Lung Disease			
8. Diabetes				18. Stomach Disease			
9. Epilepsy				19. Stroke			
10. Convulsions				20. Heart Attack <age 50			

Anything else not listed: _____

Please explain any positive answers above. _____

Personal History: Have you ever had or do you currently have: _____

	Y	N		Y	N		Y	N
1. Anemia			12. Eating problems			23. Sickle Cell Disease		
2. Arthritis			13. Fainting/Blackouts			24. Skin Trouble		
3. Asthma			14. Headaches/blackouts			25. Strep Throat- frequent		
4. Chest Pain with exercise			15. Headaches – frequent			26. Tendency to bleed		
5. Colitis			16. Heart Murmur			27. Tendency to bruise		
6. Convulsions/Epilepsy			17. Hepatitis/Jaundice			28. Tuberculosis		
7. Dental bridges/plates/braces			18. Hernia			29. Tumor		
8. Depression			19. High Blood Pressure			30. Ulcer/Stomach or other		
9. Diabetes			20. Low Blood Pressuer			31. Urinary Tract Infection		
10. Dizziness with exercise			21. Mononucleosis			32. Varicose Veins		
11. Ear Trouble/hearing loss			22. Palpitations/heart			33. Vision Difficulties.		

Others not listed? _____

Please Explain any positive answers by using their corresponding numbers: _____

List, giving dates, and explanations for any surgeries: _____

List, giving dates and explanation for any hospitalizations: _____

Are you currently taking any medications? Give names and doses: _____

Allergies:

	Y	N		Y	N		Y	N		Y	N
Allergies			Environmental			Ice			Other		
Drugs			Bees/Wasps			Latex					

Do you use a bee sting kit? Y N

Explain: _____

Women Only:

	Y	N		Y	N	
Irregular Periods			Severe Cramps			Age of menstrual onset?
Breast Lumps			Excessive Flow			

Medications Used? _____

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

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

Injuries:

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? This information will help us better care for your injuries (present/future). Please be honest and complete.

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: _____