

## 2009 SSM Summer Programs Health Form

Girl's Hockey \_\_\_\_\_ Boy's Hockey \_\_\_\_\_ Figure Skating \_\_\_\_\_ Other (please list) \_\_\_\_\_

Student Name \_\_\_\_\_ M/F \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

**History**

Circle Yes (Y) or No (N)

Athletes must have written permission from the treating physician to participate if wearing a cast.

**Have you or do you have:**

- 1. Injury or illness since your last exam? Y / N
- 2. A chronic or ongoing illness? Y / N
- 3. Ever been hospitalized? Y / N reason \_\_\_\_\_
- 4. Ever had surgery? Y / N
- 5. Allergies to medications, bee stings, pollens, or foods? Y / N  
Please list \_\_\_\_\_  
Type of reaction: \_\_\_\_\_
- 6. A heart murmur? Y / N
- 7. High blood pressure? Y / N
- 8. Restricted from sports for heart problems? Y / N
- 9. Ever had a concussion? When \_\_\_\_\_ Y / N
- 10. Ever had a head injury? When \_\_\_\_\_ Y / N
- 11. Knocked out or had memory loss? When \_\_\_\_\_ Y / N
- 12. Asthma? List medication \_\_\_\_\_ Y / N
- 13. Severe viral infection last month? Y / N
- Female Athletes:  
Do you have regular menstrual periods? Y / N  
When was your most recent menstrual period? \_\_\_\_\_  
How many periods did you have in the last year? \_\_\_\_\_

24. Have you had? (circle)

- |                   |                      |
|-------------------|----------------------|
| anemia            | sprain               |
| abnormal bleeding | diabetes             |
| abnormal bruising | dislocation          |
| broken bones      | vision loss          |
| stress fractures  | scoliosis            |
| seizures          | heart murmur         |
| viral myocarditis | depression           |
| chicken pox       | rheumatic fever      |
| hearing loss      | eating disorder      |
| single organ      | chemical dependence  |
| mononucleosis     | high blood pressure  |
| hepatitis         | sickle cell disease  |
| eye loss          | undescended testicle |
| ADD/ADHD          | other psychological  |

Explain: \_\_\_\_\_

- 25. Do you use any special equipment? Y / N
- 26. Are there other concerns you have? \_\_\_\_\_

**During or after exercise have or do you ever:**

- 14. Fainted or felt dizzy? Y / N
- 15. Had chest pain? Y / N
- 16. Had racing heart or skipped heartbeats? Y / N
- 17. Do you tire more easily than your friends? Y / N
- 18. Become ill from exercising in the heat? Y / N
- 19. Wheeze, cough, or have trouble breathing? Y / N
- 20. Has any family member or relative died of a heart problem before age 35? Y / N  
Before age 50? Y / N
- 21. Height: \_\_\_\_\_
- 22. Weight: \_\_\_\_\_
- 23. List medications currently taken daily: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to the schools athletic trainer, nurse, coach, and medical providers of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Parent or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A physical exam and written doctor's orders must be obtained before registration in order for your child to be allowed to participate if, within the last 6 months, your child has had any bouts or exacerbations of the following illnesses: asthma, diabetes, mononucleosis, 2 head injuries; or any orthopedic injury sustained within the last month.**