



# MEDICAL HISTORY

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

The Medical History must be completed annually by a parent/guardian and student in order for the student to participate in **any physical activities**. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in physical activity.

Explain any "YES" answers on a separate piece of paper. Please circle question for which you have no answer. Any "YES" answers to questions 1-28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician's assistant, chiropractor or nurse practitioner is required before any participation in any physical practices, games or matches.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or physical?			23. Have you ever had numbness in your arms, hands, legs or feet?		
2. Have you been hospitalized overnight in the past year?			24. Have you ever had a stinger, burner or pinched nerve?		
3. Have you ever had surgery?			25. Are you missing any paired organs?		
4. Have you ever passed out during or after exercise?			26. Are you presently under a doctor's care?		
5. Have you ever had chest pain during or after exercise?			27. Are you currently taking any prescription or non-prescription medications or inhalers?		
6. Do you get tired more quickly than your friends during exercise?			28. Do you have any allergies?		
7. Have you ever experienced racing of your heart or skipped heartbeats?			29. Have you ever been dizzy before or during exercise?		
8. Have you ever had high blood pressure?			30. Do you currently have any skin problems (itching, acne, wart, fungus or blisters)?		
9. Have you ever had high cholesterol?			31. Have you ever become ill after exercising or working in the heat?		
10. Have you ever been told you have a heart murmur?			32. Have you ever had any problems with your eyes or vision?		
11. Has any family member or relative died of heart problems before age 50?			33. Have you ever gotten unexpectedly short of breath with exercise?		
12. Has any family member or relative died of sudden unexpected death before age 50?			34. Do you have asthma?		
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?			35. Do you have seasonal allergies that require medical treatment?		
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?			36. Do you use any special protective or corrective equipment?		
15. Has any family member been diagnosed with Long QT Syndrome?			37. Have you ever had a sprain, strain or swelling after injury?		
16. Has any family member been diagnosed with ion Channelopathy (Brugada syndrome, etc.)			38. Have you ever broken or fractured any bones?		
17. Has any family member been diagnosed with Marfan's Syndrome?			39. Have you ever dislocated any joints?		
18. Have you had a severe viral infection (myocarditis, Mononucleosis, etc.) in the past year?			40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joint? If yes, please check the appropriate box and explain on a separate sheet of paper    Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input checked="" type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/>		
19. Has a physician ever denied or restricted you participation in sports for any heart problem?			41. Do you want to weigh more or less than you do now?		
20. Have you ever had a head injury or concussion?			42. Do you lose weight regularly to meet weight requirements for your Extra-Curricular activities?		
21. Have you ever been knocked out, become unconscious or lost your memory?			43. Do you feel stressed out?		
22. Have you ever experienced a seizure?			44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?		

45. When was your first menstrual period? \_\_\_\_\_
46. When was your most recent menstrual period? \_\_\_\_\_
47. How much time elapses from the start of one period to the start of another? \_\_\_\_\_ days.
48. How many periods have you had in the last year? \_\_\_\_\_
49. What was the longest time between periods in the last year? \_\_\_\_\_ days

If between this date and the beginning of activity, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. **Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.**

\_\_\_\_\_  
Parent/Guardian Signature

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

This Medical form reviewed by (school use only) Name \_\_\_\_\_ Date \_\_\_\_\_