

# WATAUGA COUNTY ATHLETICS

## HEALTH HISTORY

(To be completed by Student and Parents prior to examination)

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_\_

Name of Organization \_\_\_\_\_ Sport \_\_\_\_\_

### YES NO HAS THIS STUDENT HAD ANY:

1. \_\_\_ \_\_\_ Chronic or recurrent illness?
2. \_\_\_ \_\_\_ Illness lasting over one week?
3. \_\_\_ \_\_\_ Hospitalizations?
4. \_\_\_ \_\_\_ Surgery other than tonsillectomy?
5. \_\_\_ \_\_\_ Missing organs (eye, kidney, testicle)?
6. \_\_\_ \_\_\_ Allergy to any medication?
7. \_\_\_ \_\_\_ Problems with heart or blood pressure?
8. \_\_\_ \_\_\_ Chest pain with exercise?
9. \_\_\_ \_\_\_ Dizziness or fainting with exercise?
10. \_\_\_ \_\_\_ Dizziness, fainting, frequent headaches or convulsions?
11. \_\_\_ \_\_\_ Concussion or unconsciousness?
12. \_\_\_ \_\_\_ Heat exhaustion, heat stroke, or other problems with heat?

### YES NO DOES THIS STUDENT:

13. \_\_\_ \_\_\_ Wear eyeglasses or contact lens?
14. \_\_\_ \_\_\_ Wear dental bridges, braces, plates?
15. \_\_\_ \_\_\_ Take any medication?

### IS THERE ANY HISTORY OF:

16. \_\_\_ \_\_\_ Injuries requiring MD treatment?
17. \_\_\_ \_\_\_ Neck injury?
18. \_\_\_ \_\_\_ Knee injury?
19. \_\_\_ \_\_\_ Knee surgery?
20. \_\_\_ \_\_\_ Ankle injury?
21. \_\_\_ \_\_\_ Other serious joint injury?
22. \_\_\_ \_\_\_ Broken bones (fractures)?
23. \_\_\_ \_\_\_ Is there any reason why this student should not participate in sports?
24. \_\_\_ \_\_\_ Has any family member died suddenly at less than 40 years of age of causes other than an accident?
25. \_\_\_ \_\_\_ Has any family member had a heart attack at less than 50 years of age?

Date of last known Tetnus (lock jaw) shot \_\_\_\_\_

USE THIS SPACE TO EXPLAIN ANY OF THE ABOVE NUMBERED YES ANSWERS OR TO PROVIDE ANY ADDITIONAL INFORMATION.

Yes \_\_\_ No \_\_\_ I grant permission to the certified/licensed athletic trainer and/or licensed physician to administer non-prescription medications to the above named student-athlete.

SIGNATURE OF PARENT: \_\_\_\_\_

### PHYSICAL EXAMINATION

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

	NORMAL	ABNORMAL (describe abnormality)
1. Eyes	_____	_____
2. Ears, Nose, Throat	_____	_____
3. Cardiovascular	_____	_____
4. Lungs	_____	_____
5. Abdomen	_____	_____
6. Genitalia (males only)	_____	_____
7. Musculoskeletal - neck, spine, shoulders, upper extremities, hips, lower extremities	_____	_____
8. Neurological	_____	_____
9. Skin	_____	_____

BASED ON THIS HISTORY AND PHYSICAL EXAM, THE FOLLOWING ABNORMALITIES WERE FOUND AND MAY NEED TREATMENT:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### PARTICIPATION RECOMMENDATIONS

1. \_\_\_ There were no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
2. \_\_\_ This student should have the following health problems evaluated or treated prior to participating in competitive athletics: \_\_\_\_\_
3. \_\_\_ This student has health problems which would prohibit him or her from participating in competitive athletics.