PART I: HEALTH ASSESSMENT: ***Circle ALL that Apply****: Freshman Sophomore Junior Senior Transfer MDSA Potential Athlete*

(This form is to be completed by the student and parent and submitted to the Nurses' Office.)

Student Name:_____DOB:_____Home Phone:_____

Mother's Name:_____Father's Name:_____

Mother's Cell:_____ _____ Mother's Work: _____

Father's Cell:_____ Father's Work:_____

Sport(s), if applicable:_____

Have there been any changes in your health since last school year? If yes, please explain. ☐ **YES** ☐ **NO**

_____

MEDICATIONS: Please list ***ALL*** of the prescription ***(including life-saving medications…EPI-PEN, Inhaler, etc.)*** and over-the-counter (OTC) medications and supplements (herbal and nutritional) that you are currently taking:

Medication	Dose	Frequency	Reason

ALLERGIES: ☐ **YES** ☐ **NO Please specify in the space below if you have any allergies.**

Medication	Foods	Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions (i.e., Diabetes, Asthma, Anemia, etc.)? If so, please identify.		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease _____		
9. Has a doctor ever ordered a test for your heart? (example.,ECG/EKG, echocardiogram)		
10. Do you get light-headed or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured bones or dislocated joints?		
18. Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever had a stress fracture?		
20. Have you ever been told that you have or have you had an X-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
21. Do you regularly use a brace, orthotics, or other assistive device?		
22. Do you have a bone, muscle, or joint injury that bothers you?		
23. Do any of your joints become painful, swollen, feel warm, or look red?		
24. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Is there anyone in your family who has asthma?		
28. Were you born without or are you missing a kidney, an eye, your spleen, or any other organ?		
29. Do you have/had any behavioral health issues (depression, anxiety, OCD)? Please specify.		
30. Do you see/have you seen a therapist for any of these issues?		
31. Do you have any rashes or other skin problems?		
32. Have you had MRSA skin infection? When?		
33. Have you ever had a head injury or concussion? How many and what year?		
34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
MEDICAL QUESTIONS continued	**Yes**	**No**
35. Do you have a history of seizure disorder?		
36. Do you have headaches with exercise?		

37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
38. Have you ever been unable to move your arms or legs after being hit or falling?		
39. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injuries?		
44. Do you wear glasses or contact lenses?		
45. Have you had infectious mononucleosis (mono) within last month?		
46. Do you worry about your weight?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Have you ever had an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor?		
51. Have you ever had a menstrual period?		
52. How old were you when you had your first menstrual period?		
53. How many periods have you had in the last 12 months?		

Explain "YES" answers.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student: _____

Signature of Parent: _____ Date: _____