

JENKS PUBLIC SCHOOLS ATHLETIC DEPARTMENT

PRE-PARTICIPATION MEDICAL HISTORY and PARENTAL CONSENT FORM

Student ID# _____ Male Female

Student **LAST** Name _____ FIRST Name _____ MIDDLE _____

Name Uses (if different from above) _____

Date of Birth _____ Age _____ Grade 12 11 10 9 8 7

The information below is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by Physicians, Athletic Trainer, Coaches or other personnel properly trained.

SIGNATURE of ATHLETE _____ **Date** _____

SIGNATURE of PARENT / GUARDIAN _____ **Date** _____

Explain "Yes" answers at the end of questionnaire.

- | | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any allergies (i.e. medicine, food, pollen or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you been diagnosed with Sick Cell Trait? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had a severe viral infection (i.e. mononucleosis or myocarditis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you cough, wheeze or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever been diagnosed with an injury or removal of an internal organ (i.e. liver, spleen, kidney, etc.)? If so, when? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. If yes, check appropriate box and explain below. | | | | | |
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