

MEDICAL HISTORY QUESTIONNAIRE

TO BE FULLY AND ACCURATELY COMPLETED BY THE ATHLETE AND PARENT.

This questionnaire allows the Athletic Training Department to gain information on each athlete that is crucial in the prevention of injuries and in providing adequate health care during the athlete's participation at Bethany College.

Please answer all questions thoroughly and correctly. Please complete any additional information if you have any.

CIRCLE YES OR NO TO ALL QUESTIONS

- YES NO 1. Do you have an ongoing or chronic illness? _____
- YES NO 2. Have you been treated for Mononucleosis or a severe viral infection in the last year?
Date and what virus: _____
- YES NO 3. Have you ever experienced an epileptic seizure or convulsion? Date: _____
- YES NO 4. Have you had hepatitis during the past three years? Date: _____
- YES NO 5. Have you or any member of your family ever been treated for diabetes? If so who? _____
- YES NO 6. Do you have high cholesterol? _____
- YES NO 7. Do you or anyone in your family have high blood pressure? Who? _____
- YES NO 8. Have you ever been told you have a heart murmur or any other heart "trouble"?
When? _____
- YES NO 9. Does anyone in your family have heart "trouble"? Who? _____
- YES NO 10. Have you ever experienced chest pain during or after exercise? When? _____
- YES NO 11. Have you ever passed out or been "dizzy" during or after exercise? When? _____
- YES NO 12. Have you ever had racing of your heart or skipped heartbeats? When? _____
- YES NO 13. Has a physician ever denied or restricted your participation in sports for any heart problems?
Explain: _____
- YES NO 14. Has anyone in your family died suddenly before age 35 due to Health Issues? Who? _____
Before 50? Who? _____
- YES NO 15. Have you ever had a head injury or concussion? If yes, how many and their dates? _____
- YES NO 16. Have you ever had a stinger, burner, pinched nerve or any other neck injury? Date and injury: _____
- YES NO 17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? _____
- YES NO 18. Do you suffer from frequent or severe headaches (migraines)? _____
- YES NO 19. Do you wear any dental appliance? Please list: _____
- YES NO 20. Do you wear glasses or contact lenses? If yes, do you wear them during athletics? _____
- YES NO 21. Have you ever had any operations? Explain: _____
- YES NO 22. Are you allergic to anything including any medication? (examples: pollen, penicillin, food, or stinging insects)
Explain: _____
- YES NO 23. Are you currently taking any prescription or nonprescription (over-the-counter) medications (example: for acne, high blood pressure, allergies, diabetes, birth control)? _____
- YES NO 24. Do you cough, wheeze, or have trouble breathing during or after exercise? _____
- YES NO 25. Have you had or do you currently suffer from asthma? Explain: _____
If yes do you use an inhaler? _____ What kind? _____
- YES NO 26. Do you have sickle cell anemia or sickle cell trait?
- YES NO 27. (MEN) Do you have a loss of function or absence of testicles or any other related problems?
Explain: _____
- YES NO 28. (WOMEN) Do you have a menstrual cycle?
- YES NO 29. (WOMEN) Do you have any menstrual problems? Explain: _____
- YES NO 30. (WOMEN) Could you be pregnant?
- YES NO 31. Have you had any heat related illnesses (heat cramps, heat exhaustion, or heat stroke)? Explain: _____
- YES NO 32. Are you missing any organs? Explain: _____
- YES NO 33. Have you ever fractured a bone or suffered recurring sprains or strains? Indicate the anatomical site and dates: _____

Any other information that the Athletic Training Staff should know: _____

I HEREBY STATE THAT THIS MEDICAL HISTORY IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Athlete's Signature _____ Date: _____

Parent's Signature _____ Date: _____

(IF UNDER 18 YEARS OF AGE)

Bethany College Athletic Consent Form
PERMISSION FOR MEDICAL CARE

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination or immunization they deem medically necessary due to injuries I (or my son or daughter if under the age of 18) may sustain while participating in Bethany College athletics. In the event of serious illness, the need for major surgery, or significant accidental injury, the treatment necessary for the best interest of the athlete may be given.

Permission is given to the Bethany College Athletic Training staff, under the guidance of the team physician and the policies and procedures set forth by Bethany College Athletic Training Program, to render any preventative, first aid, rehabilitative, or emergency treatment they deem reasonable necessary to preserve and/or improve my (or my son's or daughter's) health and well-being.

Date: _____ Athlete's Signature: _____
Parent's Signature: _____
(IF UNDER 18 YEARS OF AGE)

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

This authorizes the Bethany College athletic trainers to release medical information about me (or my son or daughter if under 18 years of age) including information concerning illness, or injury relative to my past, present, or future participation in athletics at Bethany College (or my son or daughter's past, present or future participation) to my parents, coaches, health care professionals providing treatment to me, and insurance carriers.

By signing this form, I understand that the medical information may be protected by the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974, and that my authorization is necessary for its release. Further, I release Bethany College of any and all legal responsibility or liability that may arise from this authorization.

Date: _____ Athlete's Signature: _____
Parent's Signature: _____
(IF UNDER 18 YEARS OF AGE)

SHARED RESPONSIBILITY FOR SAFETY & ASSUMPTION OF RISK FORM

I am aware of playing or practicing to play/participate in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of participating in my chosen sports include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to participate in the sports of my choice may result not only in a serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social, recreational activities, and generally to enjoy life.

Because of the dangers of participating in athletic programs, I recognize the importance of following the coaches' instructions regarding playing techniques, training and other team rules, and to agree to obey such instructions. I also agree to comply with the safety guidelines and following training room rules and procedures; report all physical problems to the athletic trainer and follow the recommendation and instructions for treatment and prevention of injuries given to me by the athletic training staff and my medical providers.

In consideration of Bethany College permitting me to engage in all activities related to the sports of my choice, including, but not limited to trying out, practicing or playing/participating in that sport. I hereby assume all risks associated from any and all liability, actions, causes of actions, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in Bethany College athletic teams. The terms hereof shall serve as a release and assumption or risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Date: _____ Athlete's Signature: _____
Parent's Signature: _____
(IF UNDER 18 YEARS OF AGE)

For the academic year of 2011-2012, I will be participating in the following sports:

Physical Examination

(To be completed by Physician)

Last Name: _____ First Name: _____ Age: _____ (yrs)

Height: _____ (inches) Weight: _____ Blood Pressure: _____ Pulse: _____

Region	Normal	Abnormal	Explanatory Note	Region	Normal	Abnormal	Explanatory Note
Eyes-Distant Vision							
Snellen Chart R				Liver			
L				Spleen			
Corrected R				Kidneys			
L							
Pupils (L and A)				Genetalia-Hernia			
Lids				Scrotum, Testes			
E.O. Muscles				Other			
Ears-Hearing				Anal-Hemorrhoid			
Canals				Pilonidal cyst			
Drums				Other			
Nose-Throat-Gums				Orthopedics			
Dental Repair				Posture			
Pharynx				Spine			
Other				*Lordosis			
				*Kyphosis			
Neck-Thyroid				Extremities/Reflexes			
Other				*Knees			
Lymphatic glands				*Shoulders			
				*Elbows			
Chest-Inspection				*Ankles			
Pulmonary findings				*Feet			
Breasts				*Hands			
Axillary nodes							
				Nervous Conditions			
Heart-Size				Tremor			
Rhythm				Speech			
Thrills				Motor paralysis			
Murmurs							
				Emotional Stability			
Abdomen-Scars				Evidence of			
Tenderness				Psychiatric disorders			
Masses							

Physical Activity: Unrestricted _____ Restricted _____ Duration _____

Intercollegiate Athletics: Unrestricted _____ Restricted _____ Duration _____

Details for restrictions: _____

Recommendations: _____

How long have you known the patient? _____ Date of Examination: _____

Physician's Name: _____ Physician's Signature: _____

(please print)

Physician's Address: _____
