Erskine Academy Athletics Pre-participation Health Form/History

(To be filled out by student & parent/guardian) **Date:**_____

Name:_____ Sex:__ Age:_____ Date of Birth:_____Grade:_____

Sport:(fall)_____,(winter)_____,(spring)_____

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Address:_____(address city,state,zip) Phone:_____

Explain "Yes" answers below:

1. Have you ever been hospitalized?.....	Yes	No
2. Have you ever had surgery?.....	Yes	No
3. Are you presently taking any medications or pills?.....	Yes	No
4. Do you have any allergies (medicine, bees, or other stinging insects)?.....	Yes	No
5. Have you ever passed out during or after exercise?.....	Yes	No
6 .Have you ever been dizzy during or after exercise?.....	Yes	No
7. Have you ever had chest pain during or after exercise?.....	Yes	No
8.Do you tire more quickly than your friends during exercise?.....	Yes	No
9. Have you ever had high blood pressure?.....	Yes	No
10.Have you ever been told that you have a heart murmur?.....	Yes	No
11. Have you ever had racing of your heart or skipped heart beats?.....	Yes	No
12. Has anyone in your family died of heart problems or a sudden death before age 50?.....	Yes	No
13. Do you have any skin problems (itching, rashes, acne)?.....	Yes	No
14. Have you ever had a head injury?.....	Yes	No
15. Have you ever been knocked out or unconscious?.....	Yes	No
16. Have you ever had a seizure?.....	Yes	No
17. Have you ever had a stinger, burner or pinched nerve?.....	Yes	No
18. Have you ever had heat or muscle cramps?.....	Yes	No
19. Have you ever been dizzy or passed out in the heat?.....	Yes	No
20. Do you have trouble breathing or do you cough during or after activity?.....	Yes	No
21. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.).....	Yes	No
22. Have you had any problems with your eyes or vision?.....	Yes	No
23. Do you wear glasses or contacts or protective eye wear?.....	Yes	No

24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?.....

Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Foot ___Forearm ___
Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand ___

25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?.....
26. Have you had any medical problem or injury since your last evaluation?.....
27. When was your last tetanus shot?_____
28. When was your last measles immunization?_____

Explain "Yes" answers (use additional paper if needed):

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_____

_____

Signature of Athlete:_____ Date:_____

Signature of parent/guardian:_____ Date:_____