ATHLETE MEDICAL FORM

(to be completed by the athlete/parent)

Name (last, first)____ **DOB**: ___________________ **AGE**: ___________

Address ____

City____ **State**__________ **Zip Code**_____________________

Home Phone #_______________________________ **Emergency Phone #** _________________________________

INSURANCE INFORMATION:

Insurance Company __________________________________ Policy Number ______________________________

Dental Insurance Company ____________________________ Policy Number ______________________________

DIAGNOSIS:____ **SEX**: ☐ Male ☐ Female

In case of emergency whom should we notify? ____

ALLERGIES (be specific):

Medications____

Environmental/food/other ____ Latex: ☐ Yes ☐ No

What are your symptoms from an allergic reaction?

____

____

CURRENT MEDICATIONS: ____

____

PAST SURGERIES:____

____

____

Do you have a shunt in place? ☐ Yes ☐ No

Have you ever had a shunt malfunction? ☐ Yes ☐ No

If yes, what were the symptoms? ____

Have you ever had a tethered spinal cord? ☐ Yes ☐ No

If yes, what were the symptoms? ____

Have you ever been knocked out or had a concussion? ☐ Yes ☐ No

If yes, describe the incident. ____

Do you have any history of seizures? ☐ Yes ☐ No

Do you have a history of heart disease, heart murmurs, or high blood pressure? ☐ Yes ☐ No

Has anybody in your family had a sudden death or heart attack before 50 years? ☐ Yes ☐ No

Have you ever been dizzy or passed out with exercise? ☐ Yes ☐ No

Have you ever had any fractures, sprains, or strains (F=fracture, S=strain or sprain)?

Neck ______________ Arm ___________ Hip_______________ Elbow_________________

Back_______________ Hand___________ Thigh_____________ Knee__________________

Shoulders___________ Fingers_________

Do you have scoliosis? ☐ Yes ☐ No

Have you had a back fusion? ☐ Yes ☐ No

Do you have any organs missing? ☐ Yes ☐ No

Specify:____

Do you wear ☐ glasses ☐ contact lenses ☐ hearing aides ☐ dental appliances (check all that apply)

What type of bladder management do you use? (check all that apply)

☐ None ☐ Indwelling catheter ☐ Intermittent catheter

Other (specify)____

Have you had any recent (last 3 months) bladder infections? ☐ Yes ☐ No

Do you have any problems with constipation or loose stools? ☐ Yes ☐ No

Do you have any history of pressure ulcers requiring surgery? ☐ Yes ☐ No

Do you have any current pressure sores? ☐ Yes ☐ No

Where are they and how are you treating them?

1)____

2)____

What type of wheelchair cushion do you use? ______________________________

Do you have any chronic illnesses? ☐ Yes ☐ No (If Yes, specify)____________________

Date of last tetanus shot ____________________

Are your other immunizations up-to-date? ☐ Yes ☐ No (If NO, why) ____________________

Do you wear braces? ☐ Yes ☐ No What type? ______________________________

How many hours per week do you train? ______________________________

Do you have a coach? ☐ Yes ☐ No Who? ______________________________

What sports do you participate in? ______________________________

Do you have any problems with: (check all that apply):

Overheating____________ Dysreflexia____________ Spasticity ________ Pain____________

Are any of the problems made worse by exercise? ☐ Yes ☐ No (specify)____________________

Are any of the problems made better by exercise? ☐ Yes ☐ No (specify)____________________

Permission is given to the competition organizing committee to seek medical care in case of emergency for the above named person.

______________________________ ____________________

Signature Date

______________________________ ____________________

Signature of Parent/Guardian if person is under age 18 Date

The information provided on this form will be used by the medical staff for this event only. The form will be destroyed at the end of the event.