



DCSD Athletic/Activity Medical Information

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M F

Year in School: 9th 10th 11th 12th Sport (s): \_\_\_\_\_

Allergies: (include medication, food, latex or other allergies):
▪ \_\_\_\_\_ ▪ \_\_\_\_\_ ▪ \_\_\_\_\_

Medications (List ALL you are currently taking, including birth control pills):
▪ \_\_\_\_\_ ▪ \_\_\_\_\_ ▪ \_\_\_\_\_

- Date of last Tetanus shot: \_\_\_\_\_
List any body piercing you have other than on your ears: \_\_\_\_\_
List any surgeries you have had and the approximate date(s): \_\_\_\_\_

\*\*Please answer the following questions carefully and as accurately as possible. If you answer yes to any question, please provide the date of occurrence and the care that was received\*\*

Concussion History: It is extremely important that this be honest and accurate.

How many and when? \_\_\_\_\_
Did you lose consciousness? Yes \_\_\_ No \_\_\_ Did you require care by a doctor? Yes \_\_\_ No \_\_\_
Have you ever been told by a doctor that you could not participate in a practice or game following a concussion? Yes \_\_\_ No \_\_\_
Have you ever been advised by a doctor to wear protective head gear during sports? \_\_\_\_\_
Do you wear any type of protective head gear during sports? \_\_\_\_\_

Table with 2 columns: Question, YES, NO. Rows include: Have you ever been dizzy during or after exercise?, Have you ever had chest pain during or after exercise?, Do you tire more quickly than your friends during exercise?, Has anyone in your family died of heart problems before 50?, Do you have any skin problems (itching, rashes, acne)?, Have you ever had heat or muscle cramps?, Have you ever had a stinger, burner or pinched nerve?, Have you ever been dizzy or passed out in the heat?, Do you have any special equipment (braces, mouth or eye guards)?

Please answer the following:

Have you ever had an injury or a fracture to any of the following:

Table with 3 columns: Injury Type, YES, NO, When/Treatment. Rows include: 1. Head/neck, 2. Spine, 3. Shoulder(s), 4. Elbow, 5. Wrist, 6. Hand, 7. Hip, 8. Knee, 9. Ankle, 10. Foot

**Have you ever had any of the following:**

	<b>YES</b>	<b>NO</b>	
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
▪ If yes, are you insulin dependent:	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
2. Bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
3. Mono	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
4. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____ Type _____
5. Irritable bowel, colitis, or Crohn disease	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
6. Collapsed lung	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
7. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
▪ If yes, do you use an inhaler/nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	(circle)
8. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
9. Trouble Breathing or Coughing during exercise	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
10. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
11. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
12. Racing or skipped heart beats	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
13. Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
14. Eye infections	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
15. Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
▪ If yes to contacts, Do you wear hard or soft lenses?	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
			<b>Hard Soft (circle)</b>
16. Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
17. Thyroid or adrenal disorder	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
18. Blood or clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
19. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
20. Seizure or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
21. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
22. Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____
23. Migraines	<input type="checkbox"/>	<input type="checkbox"/>	When/Treatment _____

**Females Only:**

Date of first menstrual period: \_\_\_\_\_

Do you ever miss your periods: \_\_\_\_\_

Please print your name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_