Hudson City School District
www.hudsoncityschooldistrict.com
215 Harry Howard Avenue
Pam Adamo RN, Hudson Jr/Sr High School
Hudson, New York 12534
518-828-4360, ext. 8311 or ext. 3107
Fax: 518-697-8418

PRE-PARTICIPATION HISTORY

Name: ________________________ Sex: M F Age: _______ Date of Birth: ________________ Grade: __________
Address: ____ Telephone: __________________________
Personal Physician: ___________________________________ Physician Tel #: ____________________ Sport: _________________

Attention: Please be sure to read carefully and answer the following questions to the best of your knowledge

General Medical History

1. Do you have asthma? Yes No
2. Do you have diabetes? Yes No
3. Do you have high blood pressure? Yes No
4. Do you have seizures? Yes No
5. Do you have sickle cell trait? Yes No
6. Do you have any other major medical problem? Yes No
7. Have you ever been hospitalized or had surgery? Yes No
8. Do you cough, wheeze or have trouble breathing with exercise? Yes No
9. Do you use an inhaler? Yes No
10. Do you have a single organ (testicle or kidney)? Yes No
11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the- counter)? Yes No
12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain or to improve performance? Yes No
13. Do you have any allergies (seasonal, insects, food or medicines)? Yes No
14. Have you ever had a rash or hives develop during or after exercise? Yes No
15. Do you have any skin problems other than acne? Yes No
16. Have you ever had a head injury, been knocked out, lost your memory, had your 'bell rung,' or had a concussion? Yes No
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No
18. Have you ever had a stinger, burner or pinched nerve? Yes No
19. Have you ever become ill from exercising in the heat? Yes No
20. Have you had mononucleosis or any significant illness in the last 60 days? Yes No
21. Do you have trouble with your eyes/vision/wear glasses? Yes No
22. Do you have trouble with your hearing/wear hearing aid(s)? Yes No
23. Do you want to weigh more or less than you do now? Yes No
24. Do you lose weight regularly to meet weight requirements for your sport or other reason? Yes No
25. Do you feel stressed out, tired or depressed? Yes No
26. Are there any other issues you would like to discuss with the doctor? Yes No
27. Are your immunizations up to date? Yes No

FEMALES ONLY
28. Are your periods regular (every month)? Yes No
29. Are your periods heavy? Yes No

Explain "YES" answers here (use back of form if needed): ____

Cardiac History

1. Have you every passed out during or after exercise? Yes No
2. Have you ever been dizzy during or after exercise? Yes No
3. Have you ever had chest pain or chest pressure during or after exercise? Yes No
4. Do you tire easily or more quickly than your friends during exercise? Yes No
5. Have you ever had racing of your heart or skipped heartbeats? Yes No
6. Have you ever been told you had a heart murmur? Yes No
7. Have you ever been told you have an enlarged or weak heart? Yes No
8. Has any member of your family a) died of heart problems or sudden death before age 50? Yes No
   b) been told they had a serious heart problem before age 50? Yes No
   c) been told they had Marfan's syndrome? Yes No
9. Has a physician ever denied or restricted your participation in sports? Yes No

Explain "YES" answers here: ____

Orthopedic History

1. Have you ever broken or fractured any bones? Yes No
2. Have you ever subluxed or dislocated any joint? Yes No
3. If you have had problems with any of the following please check. Neck, spine or back_____ shoulders_____ elbows_____
Wrists, hands or fingers_____ hips_____ knees_____ ankles, feet or toes_____ other (please identify) __________________

Explain "YES" answers here (include date of injury if known): ____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics - As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete: ____ Date: ______________________

Signature of parent: ____ Date: ______________________