20___-20___

Athletic Medical History Questionnaire

ATHLETIC OFFICE

Please complete both sides. Please print.

DATE__________________________

Student-Athlete Information:

Class Year: FR SO JR SR

____ M F
LAST NAME FIRST NAME GENDER

____
MAILING ADDRESS CITY STATE ZIP

____
TELEPHONE EMAIL ADDRESS DATE OF BIRTH

Medical History:

Yes	No	Question
O	O	Are you currently being treated for any health condition? If, yes explain: ______________________________
O	O	Have you ever had a concussion or neck injury? If, yes list how many and dates: ______________________________
O	O	Have you had any joint injuries or fractures in the last two years? If yes, list injury and dates: ______________________________
O	O	Have you had surgery for an illness or injury within the last two years? If yes, describe: ______________________________
O	O	Have you had surgery for an illness or injury within the last two years? If yes, describe: ______________________________
O	O	Do you have any blood disorders? If yes, explain: ______________________________
O	O	Do you have any eating disorders? If yes, explain: ______________________________
O	O	Have you ever been treated for heat exhaustion or dehydration? If yes, list what and dates: ______________________________
O	O	Have you had a major illness in the past twelve months? i.e, mono, pneumonia, meningitis, etc. If yes, explain: ______________________________
O	O	Have you ever passed out during or after exercise? When: ______________________________
O	O	Have you ever been dizzy during or after exercise? When: ______________________________
O	O	Have you ever experienced chest pain during or after exercise? When: ______________________________
O	O	Have you ever been told you have a heart murmur? When: ______________________________
O	O	Has any relative died of heart problems or suffered sudden death before the age of 50? If yes, who: ______________________________
O	O	Are you missing any paired organs? i.e., eyes, lungs, kidneys, etc. If yes, list: ______________________________
O	O	Has a physician ever denied or restricted your participation in sports for health reasons? If yes, explain: ______________________________
O	O	What was the date of your last tetanus shot? ______________________________

POPE JOHN PAUL II HIGH SCHOOL
120 High School Road Hyannis, MA 02601
TEL: 508.862.6336 • FAX: 508.862.6339 • WEB: www.pjp2hs.org

20___-20___

Athletic Medical History Questionnaire

ATHLETIC OFFICE

Please complete both sides. Please print.

____
PARENT/GUARDIAN FIRST NAME PARENT/GUARDIAN LAST NAME

____
MAILING ADDRESS CITY STATE ZIP

____
HOME TELEPHONE WORK TELEPHONE CELL PHONE

____
ALTERNATE EMERGENCY CONTACT FIRST NAME ALTERNATE EMERGENCY CONTACT LAST NAME RELATIONSHIP TO STUDENT-ATHLETE

____
ALTERNATE EMERGENCY CONTACT HOME TEL ALTERNATE EMERGENCY CONTACT WORK TEL ALTERNATE EMERGENCY CONTACT CELL PHONE

____
PHYSICIAN'S NAME PHYSICIAN'S TELEPHONE

Please Answer the Following:

Does this student-athlete have:

O DIABETES O EPILEPSY O HEART CONDITION O ASTHMA O HIGH BLOOD PRESSURE O OTHER _________________________

Does this student-athlete wear contact lenses to participate? O Yes O No

Please list all the medications including inhalers and directions for use:

Please list all allergies, including medications, food, and insects:

Please list any other pertinent medical information:

Please Provide Insurance Information:

____
POLICY NAME POLICY NUMBER SUBSCRIBER'S NAME

- **I give my permission for the evaluation/treatment of ___________________________________ by the certified athletic trainer and any duly licensed physician and/or hospital facility in the event of illness or injury.**
- **I also authorize transportation in an ambulance, if necessary.**
- **I verify that the responses on the medical history questionnaire & authorization for medical treatment are true to the best of my knowledge.**

____
PARENT/GUARDIAN SIGNATURE DATE