

ACEL MEDICAL HISTORY EVALUATION

PART I: INFORMATION (To be filled out by parent or guardian only)

Name: _____ Grade: _____ School: _____
Sex: M / F Age: _____ Date of Birth: _____ Home Telephone #: _____ Sports: _____
Social Security Number: _____ Address: _____ City: _____ Zip: _____
Parent's Name: _____ Parent's Employer: _____ Work Telephone #: _____
Insurance Company: _____ Policy #: _____ Family Doctor: _____

PART II: MEDICAL HISTORY (To be filled out by parent or guardian)

Has or Does this athlete

Circle & please explain all "yes" answers below

- | | | |
|--|-----|----|
| 1. Have a medical problem or injury since his/her last evaluation? | YES | NO |
| Ever not been allowed to participate in sports for a medical reason?..... | YES | NO |
| 2. Ever been hospitalized? | YES | NO |
| Ever had surgery? | YES | NO |
| Have any missing organs? (eye, kidney, testicle, etc.) | YES | NO |
| 3. Presently take any medication? | YES | NO |
| 4. Have any allergies to medicine or insect bites? | YES | NO |
| 5. Passed out during or after exercise? | YES | NO |
| Been dizzy or passed out during or after exercise? | YES | NO |
| Have chest pain during or after exercise? | YES | NO |
| Tire more quickly than his/her friends during exercise? | YES | NO |
| Have high blood pressure? | YES | NO |
| Been told he/she has a heart murmur? | YES | NO |
| Have racing of the heart or skipped heartbeats? | YES | NO |
| Have a family member that died of heart problems or sudden death before age 50? | YES | NO |
| 6. Have any skin problems? | YES | NO |
| 7. Ever had a head or neck injury? | YES | NO |
| Ever been knocked out or unconscious? | YES | NO |
| Ever had a seizure? | YES | NO |
| Ever had a stinger, burner or pinched nerve? | YES | NO |
| 8. Ever had heat cramps? | YES | NO |
| Ever been dizzy or passed out in the heat? | YES | NO |
| 9. Have trouble with breathing or coughing during or after activity? | YES | NO |
| 10. Use any special equipment? (pads, braces, neck rolls, eye guards, kidney belt, etc.) | YES | NO |
| 11. Have any problems with vision? | YES | NO |
| Wear glasses or contacts? | YES | NO |
| 12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? | YES | NO |
| 13. Have any medical problems listed below? (Please check off) | | |

_____ High Blood Pressure	_____ Rheumatic Fever	_____ Diabetes	_____ Hepatitis
_____ Mononucleosis	_____ Abnormal Bleeding	_____ Tuberculosis	_____ Asthma
_____ Sickle Cell Disease/Trait	_____ Other (list) _____		

14. List dates for last: Tetanus Shot: _____ Measles Immunization: _____
15. Female athletes, list dates for: First menstrual period: _____ Last menstrual period: _____

Longest time between periods last year: _____

Please explain all "yes" answers from above: _____

PART III: SIGNATURES

(You must answer these questions and sign for your child to be examined)

1. The information on the reverse is current and correct to the best of my knowledge YES NO
2. I give my permission for my child to be examined for school-related activities YES NO
3. If, in the judgment of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary YES NO
4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed YES NO
5. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately YES NO
6. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school YES NO

Signature of Parent/Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

PART IV: PHYSICAL (To be filled out by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)

Height		Weight		Blood Pressure	/	Pulse
SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS		
Heart						
Lung						
Other						
Abdominal						
Genitalia						
Neck						
Shoulder						
Elbow						
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Eye	Right 20/	Left 20/	Corrected?			

CLEARANCE: _____ A. Cleared
 _____ B. Cleared after further evaluation/treatment
 _____ C. Not cleared for: _____ Collision _____ Contact _____ Non-contact

RECOMMENDATIONS: _____

NAME OF MD/NURSE PRACTITIONER: _____ DATE: _____

ADDRESS: _____ TELEPHONE: _____