

The Medical History form is to assist the S.C. Athletic Trainers in providing quality athletic health care to the athletes at Springfield College. Please write neatly and complete the form in ink only. Please answer truthfully and completely. The information you provide is confidential. In a meeting prior to the start of the season, an S.C. Athletic Training staff member will ask the athlete to explain each YES response to obtain more detailed information if needed.

Please check the appropriate response for each question.

If athlete is under the age of 18, the parent/guardian must complete form.

#	Have you ever had or do you have:	Response	Comments(specific information, dates, brief explanations as needed)
1	Epilepsy or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	Mononucleosis ("Mono")	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5	Childhood Illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Heart Murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7	Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8	Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler type?
9	Hernia(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10	Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin dependent?
11	Hypoglycemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12	Shortness of Breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13	Frequent Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14	Incidents of Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15	Loss of Paired body organ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16	Concussions/head injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of most recent: Total # in past year:
17	Ever been knocked out?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of most recent: Total # of times:
18	Tooth knocked out? &/or Dental appliances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19	Recent Surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of surgery: Body Part:
20	Contact lenses/glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear during sports participation?
21	Pain, numbness down arm following blow to head or shoulder?(burner/stinger)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of most recent: Total #: Total # in past year:
22	Injury to neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

23	Injury to shoulder(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24	Injury to elbow(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25	Injury to wrist/hand(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26	Injury to back/spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
#	Have you ever had or do you have:	Response	Comments(specific information, dates)
27	Injury to chest/ribs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
28	Injury to hip(s)/pelvis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29	Injury to knee(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30	Injury to ankle(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
31	Shin Splints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32	Stress fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33	Do you wear orthotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34	Fractured/Broke a bone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
35	Injury to eye(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
36	Injury to nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37	Heat Illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38	Diagnosed with a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
39	Significant Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount lost: Length of time:
40	Significant weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount gained: Length of time:
41	Wear any special equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What type:
42	Wear any braces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
43	Take any Medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List medications:
44	High Blood Pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
45	An unhealed injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What's the injury: Occurred:
46	Any pins, plates or screws from previous surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
47	Eating Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
48	Illness, disease or disorder that has not been mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
49	Family history of heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

50	Females: Irregular or loss Menstruation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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CONSENT TO TREAT

Springfield College employs Athletic Health Care providers, such as Physicians, Certified Athletic Trainers and Registered Nurses, who are qualified to evaluate, treat and rehabilitate certain injuries you may incur while participating in the intercollegiate athletic program.

I give my permission for the Athletic Training staff to evaluate, treat, rehabilitate and refer me as appropriate.

Signature (Athlete) Date		Signature (Witness) Date
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Parent/Guardian must execute form if the athlete is under the age of eighteen (18) years.

Signature (Parent/Guardian)	Date
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STATEMENT OF CONFIDENTIALITY AND AUTHORIZATION TO RELEASE

A complete history and medical record is maintained on each athlete that participates in the intercollegiate athletic program at Springfield College. All medical information is kept confidential and access is restricted to Athletic Training staff members that are responsible for your health care. Medical information, other than general injury information and participation status to coaches, will not be released without a written authorization of release. The authorization to release form must be signed by the athlete, indicating what specific information is to be released, and who is to receive the information.

MEDICAL CLEARANCE

Pre participation Medical Clearance: All intercollegiate athletes must be medically cleared prior to the start of each sport he/she chooses to participate in. This process includes completing required forms from the Health Center and the Athletic Training Department. A physical examination by a physician (first year students) verifying that the athlete is able to participate without restrictions, all immunizations must be up to date. A written note of medical clearance is required from a Physician for Injuries and/or illness' that were sustained since the last time you were medically cleared for participation at Springfield College.

Post Injury Medical Clearance: Any athlete that sustains an injury and/or illness during his/her season that requires outside medical attention needs a written note of clearance from the treating physician. The athlete will not be eligible to participate until the written document is presented to the Athletic Training staff and/or Health Center staff. All athletes must complete five days of practice with their team before being eligible to participate in competition.

My signature below indicates that I have read this entire document and have answered the medical history questions truthfully, and to the best of my knowledge.

Signature (Athlete) Date		Signature (Witness) Date
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Parent/Guardian must execute form if the athlete is under the age of eighteen (18) years.

Signature (Parent/Guardian)	Date
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