

**RSU73 (SPRUCE MOUNTAIN)
MEDICAL QUESTIONNAIRE**

STUDENTS NAME: _____

DOB: _____ GRADE/SPORT: _____

MEDICAL INSURANCE COMPANY: _____

POLICY #: _____

To be completed by the athlete and parents annually:	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	_____	_____
2. Do you have an ongoing medical condition (like asthma or diabetes)?	_____	_____
3. Are you currently taking any prescription or over-the-counter medications or pills.	_____	_____
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	_____	_____
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	_____	_____
6. Have you had any of the following:		
a. chest pain, pressure, or discomfort during exercise?	_____	_____
b. heart racing or skip beats during exercise?	_____	_____
c. cough, wheeze or difficulty breathing during exercise?	_____	_____
d. headaches with exercise?	_____	_____
8. Has a doctor told you that you have any of the following:		
a. high blood pressure or cholesterol, a heart murmur or infection?	_____	_____
b. asthma or allergies?	_____	_____
c. sickle cell trait or sickle cell disease?	_____	_____
d. neck (atlantoaxial) instability?	_____	_____
9. Has a doctor ever ordered a test for your heart (EKG or echo)?	_____	_____
10. Does anyone in your family have:		
a. heart problems or sudden death before age 50?	_____	_____
b. Marfan syndrome?	_____	_____
c. asthma?	_____	_____
11. Have you ever spent the night in the hospital?	_____	_____
12. Have you ever had surgery?	_____	_____
13. Have you ever had the following:		
a. an injury like a sprain that caused you to miss practice or game?	_____	_____
b. broken or fractured bones, dislocated joints or stress fracture?	_____	_____
c. an injury that required a brace, cast or crutches?	_____	_____
14. Do you regularly use a brace or assistive device?	_____	_____
15. Were you born without or are you missing any limbs or organs?	_____	_____
16. Have you had mononucleosis in the past month?	_____	_____

(over)

17. Do you have any rashes, sores or other skin problems? _____
18. Have you ever had a head injury, concussion or seizure? _____
19. Do you wear contacts or glasses? _____

Explain yes answers here _____

I hereby state that to the best of my knowledge, my answers are correct.

Signature of parent

Date: _____