Spruce Mtn. High School Athletic Medical History

All Student-Athletes participating in athletics at SMHS MUST fill out and return this form completed and accurate BEFORE they are allowed to attend practices or games with their teams.

Today's Date: _____ Date of Birth: _____

Last Name: _____ First Name: _____

Grade: 9 10 11 12 Sex: M F Sport _____

Home Address: Secondary Address (If you live with someone else)

_____ _____

_____ _____

Home Phone: _____ Secondary Address Phone_____

Mother's Name: _____ Cell Phone: _____ Work: _____

Father's Name: _____ Cell Phone: _____ Work: _____

With whom do you make your primary residence? (Mom, Dad, Other): _____

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Emergency Contact: (If parents/guardians cannot be contacted)

Name: _____ Relationship to Athlete: _____

Home Phone: _____ Cell Phone: _____

Family Doctor: _____ Office Phone: _____

Insurance Company Name: _____

Do you need a referral from your insurance for medical services (except emergencies?) ____

Are you allergic to any drugs? _____

Do you have any other allergies? _____

Do you have Asthma? _____ Do you carry an inhaler? _____

Are you currently taking medication? _____

Do you wear contacts? _____

Please circle any of the following that you have had, or are currently receiving treatment for:

Anemia	Appendicitis	Eating Disorder	Bladder injury/illness
Diabetes	Epilepsy	Headaches	Heart Disease
Hernia	Spleen Injury	Mono	Menstrual Disorder
Liver Disease	Lupus	Measles	Kidney Disease
Pneumonia	Nosebleeds	Stomach Trouble	Lyme Disease
Arthritis	High/Low Blood Pressure		Vomiting During Sports

Explain any circled answers: _____

Have you ever suffered a concussion? Yes_____ No_____

If yes give approximate dates: _____ Treatment Received_____

Have you ever suffered a neck or back injury? Yes_____ No_____

If yes, explain and give approximate dates: _____

Have you ever suffered a joint injury (fracture/dislocation/sprain)? Yes_____No____

If yes, explain the joint injured, dates & treatment: _____

_____

Have you "Passed Out' during activity? _____

Have you had chest pain during activity? _____

Have you had abnormal heartbeats during activity? _____

Is there anything else the Certified Athletic Trainer should know about your overall health? _____

To the best of my knowledge, all the information on this form is accurate.

_____ _____

Signature of Parent Date Signature of Student-Athlete Date