

Case Western Reserve University

National Youth Sports Program 2009

Medical History Form/Authorization for Physical Examination and Treatment of Emergencies

Please read and respond to each of the following items. Having a medical problem or other disability does not deny your child entrance to the program. The information is vital to us planning your child's athletic program.

Child's Name: _____

	Yes	No
1.(a) Has your child/teen ever been hospitalized?	___	___
(b) Has your child/teen ever had surgery?	___	___
(c) Is your child/teen presently taking any medication?	___	___
(d) Does your child/teen have any allergies (medicine, food, insect, etc)?	___	___
(e) Has your child/teen had any medical problem or injury since the last physical?	___	___
(f) Does your child/teen have any medical problems that you have to see a doctor for?	___	___
(g) Has your child/teen been sick over the last two weeks?	___	___
(h) Does your child have Diabetes?	___	___
(i) Does your child have Sickle-Cell Anemia?	___	___
(j) Does your child have ADHD, Bipolar Disorder, Depression or any other emotional disorders?	___	___
(k) Are there any medical problems that run in your family?	___	___
[Check all that are in your family]		
Heart___ Cancer___ Kidneys___		
Lungs___ Diabetes ___ Psychiatric___ Other (please specify)_____		

If you answered "Yes" to any of the above questions (a-k), please explain.

2.(a) Has your child/teen ever passed out during or after exercise?	___	___
(b) Has your child/teen ever been dizzy during or after exercise?	___	___
(c) Has your child/teen ever had chest pain during or after exercise?	___	___
(d) Has your child/teen ever been told they have high blood pressure or high cholesterol?	___	___
(e) Has your child/teen ever been told they have a heart murmur?	___	___
(f) Has your child/teen ever told you that their heart was racing or their heart had skipped heartbeats?	___	___
(g) Has anyone in your family died of heart problems or sudden death before the age of 50?	___	___
(h) Does your child/teen get tired more quickly than their friends do during exercise?	___	___
3.(a) Has your child/teen ever had a head injury or concussion?	___	___
(b) Has your child/teen ever been knocked unconscious or lost their memory?	___	___
(c) Has your child/teen ever had an injury to their neck, a pinched nerve, or a burn?	___	___
(d) Has your child/teen ever had a seizure?	___	___

(OVER)

	Yes	No
4. Does your child/teen have any skin allergies?	___	___
5. Has your child/teen had any weight changes during the past six months?	___	___
6.(a) Has your child/teen ever had heat or muscle cramps?	___	___
(b) Has your child/teen ever been dizzy or passed out from the heat?	___	___
7.(a) Does your child/teen have trouble breathing or do they cough during or after activity?	___	___
(b) Does your child/teen wheeze or have chest pain or tightness during exercise?	___	___
(c) Does your child/teen have asthma or seasonal allergies?	___	___
8.(a) Has your child/teen had any problems with eyes or vision?	___	___
(b) Does your child/teen wear contact lenses, glasses, or protective eye wear?	___	___
9.(a) Has your child/teen ever broken or fractured any bone or dislocated any joint?	___	___
(b) Has your child/teen ever had a sprain, strain, or swelling after an injury?	___	___
(c) Has your child/teen ever injured the following:		
Head	___	___
Neck	___	___
Back	___	___
Chest	___	___
Shoulder	___	___
Elbow	___	___
Wrist	___	___
Hand/Finger	___	___
Hip	___	___
Thigh	___	___
Knee	___	___
Shin	___	___
Ankle	___	___
Foot/Toes	___	___
10.(a) When was your child/teen's last tetanus shot? _____		
(b) When was your child/teen's last measles shot? _____		
11. Does your child/teen have a regular doctor? _____		
If yes, what is the doctor's name and telephone number? _____		
If yes, when was your child/teen's last physical? _____		
12. When was the last time your child/teen had dental care from a dentist? _____		

Parent/Guardian: I hereby grant permission for my child, named above, to have a physical examination and to receive medical care/treatment, if needed, by the NYSP Medical Coordinator.

Signature _____

Home Phone _____

Work/Emergency Phone _____