NOTRE DAME HIGH SCHOOL HEALTH FORM

NAME:_____ **SPORT:**_____

ALL YES ANSWERS MUST BE EXPLAINED.

	YES	NO
1. Have you had a medical illness or injury since your last check-up or sports physical?	____	___
2. Have you ever been hospitalized overnight?	____	___
3. Have you ever had surgery?	____	___
4. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	____	___
5. Have you ever taken any supplements or vitamins to help you improve your performance?	____	___
6. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	____	___
7. Have you ever had a rash or hives develop during or after exercise?	____	___
8. Have you ever been dizzy or passed out during or after exercise?	____	___
9. Have you ever had chest pain during or after exercise?	____	___
10. Do you have diabetes?	____	___
11. Do you tire more easily than you feel you should?	____	___
12. Have you ever been diagnosed with anemia?	____	___
13. Have you ever had racing of your heart of skipped heartbeats?	____	___
14. Have you had high blood pressure?	____	___
15. Have you ever been told you have a heart murmur?	____	___
16. Has any family member or relative died of heart problems or of sudden death before age 50?	____	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	____	___
18. Has a physician ever denied or restricted your Participation in sports for any heart problems?	____	___
19. Have you ever been diagnosed with blood or bleeding disorders?	____	___
20. Do you have ONLY one kidney?	____	___
21. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters)?	____	___
22. Have you ever had a head injury or concussion?	____	___
23. Have you ever been knocked out, become unconscious, or lost your memory?	____	___
24. Have you ever had a seizure or convulsion?	____	___
25. Do you have frequent or severe headaches?	____	___
26. Have you ever had numbness or tingling in your arms, hands, legs or feet from a stinger, burner or pinched nerve or other condition?	____	___
27. Have you ever had heat cramps, heat exhaustion or heat stroke?	____	___
28. Do you cough, wheeze or have trouble breathing during or after activity?	____	___
29. Do you have asthma or lung disease?	____	___
30. Do you have seasonal allergies that require medical treatment?	____	___
31. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, foot orthotics, retainer on your teeth, hearing aid?	____	___
32. Do you wear glasses, contacts or protective eyewear?	____	___
33. Do you have any other problem with your eyes or vision?	____	___
34. Have you broken or fractured any bones or dislocated any joints or been diagnosed with a stress fracture?	____	___
35. Have you ever had a sprain, strain or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones or joints that has kept you from participating in sports?	____	___

If yes, check appropriate box and explain below.

___ Head	___Elbow	___Hip
___ Neck	___Forearm	___Thigh
___ Back	___Wrist	___Knee
___ Chest	___Hand	___Shin/Calf
___ Shoulder	___Finger	___Ankle
___ Upper Arm		___Foot

36. Do you lose weight regularly to meet weight requirements for your sport?	____	___
37. Has there been any unexplained weight loss or weight gain during the past six months?	____	___
38. Are you currently following any particular diet or weight-reducing plan?	____	___

FEMALES ONLY

39. Has there been a recent change in menstrual patterns?	____	___

40. At what age did you experience your first menstrual period? _____
41. Last menstrual period? _____/_____/_____.
42. How much time do you usually have from the start of one period to the start of another? _____
43. How many periods have you had in the last year? _____
44. What was the longest time between one menstrual cycle and the next in the last year? _____

Explain yes answers here. Identify each answer with question number.

_____

_____

_____

_____

NOTRE DAME HIGH SCHOOL MEDICAL CARD /CONSENT FORM

ATHLETE:_____

MALE:____ **FEMALE:**_____ **AGE:**_____**D-O-B:**_____

ADDRESS:_____

CITY:_____**ZIP:**_____**HOME PHONE:**_____

PARENT(S):_____

CONTACT PHONE #'S: WORK:_____**CELL**_____

WORK:_____**CELL**_____

EMERGENCY CONTACT (in event parents can't be reached):

NAME:_____**RELATIONSHIP:**_____

PHONE #'S: HOME:_____**WORK:**_____**CELL:**_____

DOCTOR:_____**PHONE #:**_____

HEALTH CONCERNS/ALLERGIES:_____

_____

_____

PARENT(S) INSURANCE CARRIER: _____

SECTION II PARENT PERMISSION/STUDENT AGREEMENT:

Our signatures indicate:

- ✓ Permission to try out for and participate in interscholastic athletics.
- ✓ Awareness that this form will be sent to Coach and Athletic Director
- ✓ The athlete and/or parent is responsible for notifying coach. AD and School Health office at time of injury.

By signing this consent form you are also acknowledging that you have received the NDHS Concussion Management Plan and that you understand how to obtain additional information on concussions from the New York State Education Department and NYS Department of Health as well as other educational materials that are posted on the ND Website Central School website. Parent consent on concussion management is required by New York State Law (Chapter 496 of the laws of New York 2011) and as per Commissioner's Regulations section 136.5.

PERMISSION FOR EMERGENCY MEDICAL TREATMENT: In the event of a medical emergency, every effort will be made to contact the parent/guardian to authorize medical treatment/hospitalization. I hereby grant permission for a physician or hospital personnel designated by Notre Dame to attend my son/daughter if I cannot be contacted (Insurance carrier listed above).

Parent Signature:_____ **Date**:_____

Student Signature:_____ **Date:**_____

(OVER)