

# Spring Hill Christian Academy

3140 Mariner Blvd., Spring Hill, FL 34609

**Part 1. Student Information** (To be completed by student or parent)...

Student Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Relationship to Student \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 Personal/Family Physician \_\_\_\_\_ City/State \_\_\_\_\_ Office Phone (\_\_\_\_) \_\_\_\_\_

**Part 2. Medical History** (To be completed by student or parent.) Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	27. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have a seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a rash or hives develop during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate blank and explain below:</i>		
12. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	___ Head	___ Elbow	___ Hip
13. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	___ Neck	___ Forearm	___ Thigh
14. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	___ Back	___ Wrist	___ Knee
15. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	___ Chest	___ Hand	___ Shin/Calf
16. Has any family member or relative died or heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	___ Shoulder	___ Finger	___ Ankle
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	___ Upper Arm	___ Foot	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	37. Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	39. Record the dates of your most recent immunizations (shots) for: Tetanus: _____ Measles: _____ Hepatitis B: _____ Chickenpox: _____		
22. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY (Optional)</b>		
23. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	40. When was your first menstrual period? _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	41. When was your most recent menstrual period? _____		
25. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	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 periods in the last year? _____		

Explain "yes" answers here: \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 11.8, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_