Hudson City School District 215 Harry Howard Ave. Hudson, NY 12534
www.hudsoncityschooldistrict.com **Hudson Jr./Sr. High School** 518-828-4360, ext. 8311 or 3107
Fax: 518-697-8798

Pierpont Geer, RN; Stephanie Haigh, LPN

PRE-PARTICIPATION HISTORY

Name:______________________________ Sex: M F Age:______ Date of Birth:_____________ Grade:__________
Address:____ Telephone:__________________________
Personal Physician:___________________________________Physician Tel. #:_______________ Sport:_________________

Attention: **Please be sure to read carefully and answer the following questions to the best of your knowledge**

General Medical History:

Question		
1. Do you have asthma?	Yes	No
2. Do you have diabetes?	Yes	No
3. Do you have high blood pressure?	Yes	No
4. Do you have seizures?	Yes	No
5. Do you have sickle cell trait?	Yes	No
6. Do you have any other major medical problem?	Yes	No
7. Have you ever been hospitalized or had surgery?	Yes	No
8. Do you cough, wheeze, or have trouble breathing with exercise?	Yes	No
9. Do you use an inhaler?	Yes	No
10. Do you have a single organ (e.g., testicle or kidney)?	Yes	No
11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)?	Yes	No
12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain or to improve performance?	Yes	No
13. Do you have any allergies (seasonal, insects, food or medicines)?	Yes	No
14. Have you ever had a rash or hives develop during or after exercise?	Yes	No
15. Do you have any skin problems other than acne?	Yes	No
16. Have you ever had a rash or hives develop during or after exercise?	Yes	No
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No
18. Have you ever had a stinger, burner, or pinched nerve?	Yes	No
19. Have you ever become ill from exercising in the heat?	Yes	No
20. Have you had mononucleosis or any significant illness in the last 60 days?	Yes	No
21. Do you have trouble with your eyes/vision/wear glasses?	Yes	No
22. Do you have trouble with your hearing/wear hearing aid(s)?	Yes	No
23. Do you want to weigh more or less than you do now?	Yes	No
24. Do you lose weight regularly to meet weight requirements for your sport or other reasons?	Yes	No
25. Do you feel stressed out, tired or depressed?	Yes	No
26. Are there any other issues you would like to discuss with the doctor?	Yes	No
27. Are your immunizations up to date?	Yes	No

FEMALES ONLY

Question		
28. Are your periods regular (every month)?	Yes	No
29. Are your periods heavy?	Yes	No

Explain "YES" answers here (attach another sheet of paper if needed): ____
____
____

(OVER)

Cardiac History

1. Have you ever passed out during or after exercise? Yes No
2. Have you ever been dizzy during or after exercise? Yes No
3. Have you ever had chest pain or chest pressure during or after exercise? Yes No
4. Do you tire easily or more quickly than your friends during exercise? Yes No
5. Have you ever had racing or you heart or skipped heartbeats? Yes No
6. Have you ever been told you had a heart murmur? Yes No
7. Have you ever been told you have an enlarged or weak heart? Yes No
8. Has any member of your family a) died of heart problems or sudden death before age 50? Yes No
   b) been told they had a serious heart problem before age 50? Yes No
   c) been told they had Marfan's syndrome? Yes No
9. Has a physician ever denied or restricted your participation in sports? Yes No

Explain "YES" answers here (attach another sheet of paper if needed): ____

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Orthopedic History

1. Have you ever broken or fractured any bones? Yes No
2. Have you ever subluxed or dislocated any joint? Yes No
3. If you have had problems with any of the following, please check:

   Neck, spine or back ____ Shoulders ____ Elbows ____ Wrists, hands or fingers ____

   Hips ____ Knees ____ Ankles, feet or toes ____ Other (identify) ___________________

Explain "YES" answers here (include date of injury, if known): ____

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Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics - As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events. I also give my permission for the physical evaluation for that participation, unless I check the box below for the physical evaluation to be complete by our primary care physician. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

____ Check **only** if you would like the physical evaluation completed by your primary care physician. By checking this, I also will provide this form and proper documentation of the physical evaluation to the Hudson Jr./Sr. High School Nurse to be reviewed by the school health professional.

Signature of Athlete: ____ Date: _____________________

Signature of Parent: ____ Date: _____________________

Updated 8/5/2019