# ATHLETE MEDICAL FORM

## (to be completed by the athlete/parent)

**NAME** (last, first)________________________________________ **DOB**:___________**AGE**:________

**Address** __________________________ **City** __________________ **State** ______ **Zip Code** ______

**Home Phone #**_________________________ **Emergency Phone #** ____________________________

**INSURANCE INFORMATION**:

Insurance Company _________________________________ Policy Number __________________

Dental Insurance Company ____________________________ Policy Number __________________

**DIAGNOSIS**:____________________________________ **SEX**: M F (circle one)

In case of emergency whom should we notify?________________________________________________

**ALLERGIES (be specific):**

Medications________________________________________________________________

Environmental/food/other_________________________________________Latex (yes/no)________

What are your symptoms from an allergic reaction?___________________________________________

________________________________________________________________________________

**CURRENT MEDICATIONS**: _________________________________________________________

________________________________________________________________________________

**PAST SURGERIES**:_______________________________________________________________

________________________________________________________________________________

Do you have a shunt in place? Y N (circle one)

Have you ever had a shunt malfunction? Y N (circle one)

If yes, what were the symptoms?______________________________________________________

Have you ever had a tethered spinal cord? Y N (circle one)

If yes, what were the symptoms?______________________________________________________

Have you ever been knocked out or had a concussion? Y N (circle one)

If yes, describe the incident.________________________________________________________

Do you have any history of seizures? Y N (circle one)

Do you have a history of heart disease, heart murmurs, or high blood pressure? Y N (circle one)

Has anybody in your family had a sudden death or heart attack before 50 years? Y N (circle one)

Have you ever been dizzy or passed out with exercise? Y N (circle one)

Have you ever had any fractures, sprains, or strains (F=fracture, S=strain or sprain)?

Neck__________________Arm__________________Hip__________________Elbow_________________

Back__________________Hand_________________Thigh_________________Knee__________________

Shoulders___________________ Fingers____________________

Do you have scoliosis? Y N (circle one)

Have you had a back fusion? Y N (circle one)

Do you have any organs missing? Y N (circle one)

Specify:_____________________________________________________________________________________

Do you wear glasses, contact lenses, hearing aides, or dental appliances ? (circle all that apply)

What type of bladder management do you use? (check all that apply)

None_________ Indwelling catheter_________ Intermittent catheter_________

Other (specify)___________________________________________________________________________

Have you had any recent (last 3 months) bladder infections? Y N (circle one)

Do you have any problems with constipation or loose stools? Y N (circle one)

Do you have any history of pressure ulcers requiring surgery? Y N (circle one)

Do you have any current pressure sores? Y N (circle one)

Where are they and how are you treating them?

1)__________________________________________________________________________________________

2)__________________________________________________________________________________________

What type of wheelchair cushion do you use?___________________________________________________

Do you have any chronic illnesses? Y N (circle one & and specify)__________________________

Date of last tetanus shot._________________

Are your other immunizations up-to-date? Y N (circle one & if no, why)_____________________

Do you wear braces? Y N (circle one) What type?__________________________________________

How many hours per week do you train?_______________

Do you have a coach? Y N (circle one) Who?____________________________________________

What sports do you participate in?___________________________________________________________

Do you have any problems with (check all that apply):

Overheating____________ Dysreflexia_______________ Spasticity______________ Pain________________

Are any of the problems made worse by exercise? Y N (circle one & specify)________________

Are any of the problems made better by exercise? Y N (circle one & specify)________________

Permission is given to WSUSA or competition organizing committee to seek medical care in case of emergency for the above named person.

______________________________________________ ________________________________________

Signature Date

______________________________________________ ________________________________________

Signature of Parent/Guardian if person is under age 18 Date