HINKLETOWN MENNONITE SCHOOL
ATHLETIC PRE-PARTICIPATION HEALTH FORM
HEALTH HISTORY QUESTIONNAIRE
(To be completed by a parent/guardian)

Student's Name: _____ Today's Date:_____
Address: _____

Sex: M F (circle one) Age: _____ Date of Birth: _____

Sport: _____ Grade: _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, illness or accident, please authorize the coach, athletic director, or another responsible adult to proceed as indicated below. Number from 1 – 6.

(____)Parent contact:
Name: _____Relationship to student: _____

Phone (work): _____Phone (home):_____

Phone (cell): _____

(____)Parent contact:

Name: _____Relationship to student: _____

Phone (work): _____Phone (home):_____

Phone (cell): _____

(____) **Other emergency contact:**

Name:_____Relationship to student:_____

Phone (work)_____Phone (home): _____

Phone (cell):_____

(____) FamilyPhysician: _____

Phone: _____

(_____) **Emergency hospital:**
list preference_____

(_____) Other procedure:

Date of last physical: _____

Date of last tetanus shot: _____

Family Dentist _____

Phone Number:_____

Directions: Please answer the following questions about the student's medical history**. Explain all "yes" responses at the bottom of the page**. Please respond to all questions.

1. Have you had or do you currently have:
   a. A physical within the past 365 days? Yes No Don't Know
   b. An injury or illness the past year? Yes No Don't Know
   c. A chronic or ongoing illness (such as diabetes or asthma)? Yes No Don't Know
   d. Use an inhaler or other prescription medicine to control asthma? Yes No Don't Know
   e. Take prescribed or over the counter medications that you take on a regular basis? Yes No Don't Know
   f. Surgery, hospitalization or any emergency room visit(s)? Yes No Don't Know
   g. Any allergies to medications? Yes No Don't Know
   h. Any allergies to bee stings, pollen, latex or foods? Yes No Don't Know
   i. Type of reaction: Rash? Hives? Other skin condition? Yes No Don't Know
   j. Take any medication/Epipen taken for allergy symptoms? Yes No Don't Know
   k. Any anemias or blood disorders? Yes No Don't Know
   l. Any eating disorders (bulimic, anorexia)?

2. Have you had or do you currently have any of the following *head-related* conditions?
   a. Concussion requiring a physician's evaluation? Yes No Don't Know
   b. Memory loss or been knocked out? Yes No Don't Know
   c. A seizure? Yes No Don't Know
   d. Frequent or severe headaches? Yes No Don't Know

3. Have you had or do you curently have any of the following *heart-related* conditions ?
   a. Chest pain? Yes No Don't Know
   b. Heart murmur or irregular heart beat? Yes No Don't Know
   c. High blood pressure or elevated cholesterol level? Yes No Don't Know
   d. Restriction from sports for heart problems? Yes No Don't Know
   e. Have a family member or relative with heart problems before the age of 25? Yes No Don't Know

4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions*?
   a. Vision problems? Yes No Don't Know
      1. Wear contacts, eyeglasses or protective eyewear? (Circle which type.)
   b. Hearing loss or problems? Yes No Don't Know
      1. Wear hearing aides or implants? (Circle which type.)
   c. Nasal fractures or frequent nose bleeds? Yes No Don't Know
   d. Wear braces, retainer or protective mouth gear? Yes No Don't Know
   e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Yes No Don't Know

5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions?*
   a. A burner, stinger or pinched nerve? Yes No Don't Know
   b. A sprain? Yes No Don't Know
   c. A strain? Yes No Don't Know
   d. Swelling or pain in muscles, tendons, bones or joints? Yes No Don't Know
   e. A dislocated joint(s)? Yes No Don't Know
   f. Upper or lower back pain? Yes No Don't Know

g. Fracture(s) or stress fracture(s)? Yes No Don't Know
h. Do you wear any protective braces or equipment for any prior injury? Yes No Don't Know

6. Have you had or do you currently have any of the following *general or exercise related conditions*?
   a. Difficulty breathing during exercise or after running one mile? Yes No Don't Know
   b. Coughing, wheezing or shortness of breathe in weather changes? Yes No Don't Know
   c. Exercise-induced asthma Yes No Don't Know
   d. Experience dizziness, passing out or fainting during or after exercise? Yes No Don't Know
   e. Heat-related problems (dehydration, dizziness, fatigue, headache)? Yes No Don't Know
   f. Heat exhaustion (cool, clammy, damp skin)? Yes No Don't Know
   g. Heat stroke (hot, red, dry skin)? Yes No Don't Know
   h. Viral infections (e.g. mono, hepatitis)? Yes No Don't Know
   i. Become tired more quickly than your friends? Yes No Don't Know
   j. Any of the following skin conditions:
      1. Acne, contact dermatitis, ringworm, warts? Yes No Don't Know
      2. Sun sensitivity? Yes No Don't Know
   k. Sudden weight gain/loss (greater than or less than 10 pounds)? Yes No Don't Know
   i. Dealt with feelings of depression or suicide? Yes No Don't Know

Explain all (yes) answers here (include relevant dates): List the number and letter prior to the explanation.

_____
_____
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_____

(Use the back of this sheet if more space is needed.)

____I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.
____In the event I cannot be reached in an emergency I hereby give permission to the attending physician to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my child.
____I am aware that Hinkletown Mennonite School does not have insurance coverage for injuries that result at school or other off campus events.

Parent/Guardian Signature:_____ Date:_____