Durham Public Schools
Medical History Athletic Participation Form

This form should be completed by parent or guardian *prior* to the physical examination and *taken* to the physician for review when the physical examination is given.

Student Information:

Name: _____ Grade_____

Address:_____ City:_____

_____ State:_____ Zip:_____

I intend to play the following sport(s):_____

I certify that all the information is correct, and I agree to abide by the eligibility rules and regulations of my school and the North Carolina High School Athletic Association.

Parent/Guardian Information:

Name:_____ Relationship:_____

Telephone Numbers: _____

Home Work Cell

Emergency Contact: _____

Home Work Cell

Student's Physician:_____

Address of Attending Physician Phone Number

Student's Social Security Number: _____ Date of Birth: _____

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Please explain any answers to questions 1-15 in the "yes" column below.

Yes	No	
___	___	Have you ever had any of the following? Broken bones_____ weak joints-ankles, knees_____ *spinal injury*_____ Seizures or epilepsy _____ concussions_____operation_____
___	___	Shoulder or neck pain such as a "burner" or "stinger"
___	___	Injury or illness that excluded athletic participation previously
___	___	Heat or muscle cramps

Cardiovascular History:

___	___	Have you ever fainted or passed out?
___	___	Have you ever had a chest pain or discomfort with exercise?
___	___	Have you ever had to stop running or exercising because of chest pains or shortness of breath?
___	___	Have you ever had excessive, unexpected or unexplained shortness of breath associated with exercise?
___	___	Have you ever had excessive, unexpected or unexplained fatigue associated with exercise?
___	___	Have you ever been diagnosed with a heart murmur?
___	___	Have you ever had high blood pressure or hypertension?
___	___	Has any family member died prematurely (before age 50) sudden – health related?
___	___	Is there any family history of significant disability due to cardiovascular disease in a close relative less than 50 years of age?
___	___	Do you have any specific knowledge of the occurrence of specific cardiovascular condition such as: Hypertrophy cardiomyopathy, dilated cardiomyopathy, long OT syndrome, Mar fan Syndrome, or clinically important arrhythmias?
___	___	Do you get tired more quickly that you friends during exercise?
___	___	Have you ever been knock out?
___	___	Have you ever been hospitalized?
___	___	Have you ever had significant allergies to:
___	___	Bee strings
___	___	Foods
___	___	Medicine
___	___	Other?
___	___	Do you have prescription use for Adrenaline, Inhaler, or other allergy medicine?
___	___	Do you have asthma
___	___	Do you take any medicine/supplements regularly?