ARCHBISHOP CURLEY HIGH SCHOOL

STUDENT HEALTH QUESTIONNAIRE
2018-2019 Academic Year

NAME: _____ _____ Sex: _____ Grade: _____ Sport: _____
Last First MI D.O.B.

ADDRESS: _____
Street City State Zip

MOTHER: _____ **FATHER:** _____

Telephone Home: _____ Telephone Home: _____

Cell: _____ Cell: _____

Work: _____ Work: _____

Email: _____ Email: _____

Parent or Guardian whom child resides with primarily: ***Mother*** ☐ ***Father*** ☐ ***Both*** ☐ ***Other*** ☐

STUDENT HEALTH INSURANCE PROVIDER

_____
Name of Company

_____ _____
Policy Number Group Number

EMERGENCY CONTACT PERSON (other than parents)

NAME: _____

Telephone Home: _____

Cell Phone: _____

This section is to be completed by parent or legal guardian.

GENERAL MEDICAL HISTORY	YES	NO
1. Does your child have any ongoing medical condition currently? If YES, please explain:	☐	☐
2. Has your child been advised by a physician NOT to participate in any activity (SPORTS) within the last 12 months? If YES, please describe and give date(s).	☐	☐
3. To the best of your knowledge, has your child had any problems with the following?		

	YES	NO	COMMENT		YES	NO	COMMENT
Allergies: medicine	☐	☐		Heart Problems	☐	☐	
Allergies: food	☐	☐		Hernia	☐	☐	
Anaphylaxis	☐	☐		Hospitalization	☐	☐	
Anemia	☐	☐		Learning Disabilities	☐	☐	
Asthma	☐	☐		Meningitis	☐	☐	
Behavior/Emotional	☐	☐		Migraines	☐	☐	
Birth Defects	☐	☐		Nasal Problems	☐	☐	
Bleeding Problems	☐	☐		Physical Disabilities	☐	☐	
Dental	☐	☐		Prematurity	☐	☐	
Diabetes	☐	☐		Seizures	☐	☐	
Ear Problem/Deafness	☐	☐		Sickle Cell Disease	☐	☐	
Eye or Vision Problems	☐	☐		Speech Problems	☐	☐	
GI Problems	☐	☐		Surgery	☐	☐	
GU Problems	☐	☐		Throat	☐	☐	
Head Injury	☐	☐		Other	☐	☐	

GENERAL MEDICAL HISTORY **Continued**	YES	NO
4. Has your child ever had one of the following? ☐Mononucleosis ☐Hepatitis ☐Tuberculosis ☐Other infectious disease? _____	☐	☐
5. Does your child have any rashes, pressure sores, or other skin problems?	☐	☐
6. Is your child missing a kidney, eye, testicle, or other organ? _____	☐	☐
7. Does your child bruise easily?	☐	☐
8. Does your child have or have they ever had (Check all that apply): ☐Hearing loss ☐Perforated Ear Drum ☐Recurrent Ear Infections ☐Different Eye color ☐Unequal Pupils ☐Sinus Infection ☐Fracture/Broken Nose ☐Loose or Broken Teeth/ Dental Implants	☐	☐
9. Does your child have impaired vision (other than wearing glasses) in: LEFT EYE RIGHT EYE	☐	☐

MEDICATION	**YES**	**NO**
10. Does your child take Medications regularly? If YES, please list and explain for what use:	☐	☐
11. Does your child take MEDICATIONS for EMERGENCY USE? If YES, please list:	☐	☐
12. IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? If YES, please list:	☐	☐
FAMILY HISTORY	**YES**	**NO**
13. Has anyone in your immediate family had or have: ☐Asthma ☐Diabetes ☐Anemia ☐Migraines ☐Kidney Problems ☐Epilepsy ☐High Blood Pressure If checked, state relation to student (parent, sibling, and aunt/uncle): _____	☐	☐
14. Has a family member or relative died of heart problems or sudden death before age 50?	☐	☐
15. Has your child been diagnosed OR has anyone in your family been diagnosed with Marfan's syndrome?	☐	☐
16. Does your child have the SICKLE CELL TRAIT or SICKLE CELL DISEASE? Specify which _____	☐	☐
CARDIOVASCULLAR/RESPIRATORY	**YES**	**NO**
17. Has a doctor ever told you that your child has: (check all that apply) ☐High Blood Pressure ☐Heart Murmur ☐Enlarged Heart ☐Heart Infection ☐High Cholesterol	☐	☐
18. Has your child ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
19. Has your child ever had discomfort, pain, pressure, or rapid heartbeat during exercise?	☐	☐
20. Has your child ever used an inhaler or taken asthma medication? If yes what medication: _____	☐	☐
21. Does your child cough, wheeze, have shortness of breath or have difficulty breathing during or after exercise?	☐	☐
HEAT PROBLEMS	**YES**	**NO**
22. Has your child ever had problems with exercising in heat or hot weather?	☐	☐
23. When exercising in the heat, does your child ever have severe muscle cramps?	☐	☐
24. Has your child had episodes of Heat Illness, Dehydration, Heat Exhaustion, or Heat Stroke? If YES explain/Specify:	☐	☐
ORTHOPEDIC	**YES**	**NO**
25. Has your child ever had a muscle strain or sprain, pull or tear? If YES specify body part(s):	☐	☐
26. Has your child broken, fractured or dislocated any bones? If YES specify body part(s):	☐	☐
27. Has your child had problems with pain or swelling in muscles, tendons, bones or joints? If YES specify body part(s):	☐	☐
HEAD & NECK PROBLEMS	**YES**	**NO**
28. Has your child ever been diagnosed with a **HEAD INJURY / CONCUSSION** (Mild Traumatic Brain Injury) by a Medical Professional (MD, DO, PA, Athletic Trainer, Nurse)?	☐	☐
IF YES: - How many concussions has your child had?		
- Please list date of most recent concussion:		
29. Has your child been hit in the head and been confused or lost memory or lost consciousness?	☐	☐
30. Has your child ever had a seizure?	☐	☐
31. Has your child been diagnosed with Epilepsy?	☐	☐
32. Does your child have headaches with exercise?	☐	☐
33. Has your child ever had temporary loss of vision after being hit in the head or falling?	☐	☐
34. Has your child ever had a neck injury?	☐	☐
35. Has your child ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?	☐	☐
36. Has your child ever been unable to move his/her arms or legs after being hit or falling?	☐	☐

Please explain any additional important medical information the medical staff at Archbishop Curley High School should be aware of (i.e. surgeries, illnesses, conditions, etc….)

CONSENT & WAIVER FORM

NAME: _____ GRADE: _____ SPORT:_____

BY SIGNING BELOW, I/WE CERTIFY THAT:

I. PARENTAL CONSENT TO TREAT:

A. Permission is hereby granted to the Archbishop Curley High School Certified: Athletic Trainers, Nurses, Faculty and Coaches to proceed with any necessary Primary and Secondary First Aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant will be given.

B. Permission is hereby granted to the Archbishop Curley High School Certified/Licensed Athletic Trainers to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation of injuries for the above-named student/athlete.

C. Permission is hereby granted to the Archbishop Curley High School Certified/Licensed Athletic Trainers to proceed with any necessary use of modalities (including but not limited to: Moist Heat, Ultrasound, Electric Stimulation, T.E.N.S, Light Therapy, Paraffin Bath, Compression Unit, Whirlpools) for the care, treatment and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the direction of the Archbishop Curley High School Team physician and/or other referring physicians and will only be administered by the Archbishop Curley High School Certified Athletic Trainers.

D. XLNTbrain Testing: Permission is granted for the above named student-athlete to participate in completing a Baseline XLNTbrain test. The baseline will be stored in a database for later use should the athlete sustain a head injury, concussion or mild traumatic brain injury (MTBI).

II.CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to the Archbishop Curley High School Certified Athletic Trainers to distribute medication/topical substances (listed below) to the above-named student athlete. Please indicate if your son **SHOULD NOT** have any of the following medications.

Acetaminophen(Tylenol or generic- 500mg)	Gold Bond Powder	New Skin Liquid Bandage
Aleve(220mg)	Medi-Lyte / Heat Aid *	Non-Pseudo Sinus Decongestant**
Bacitracin	Hydrocortisone 1.0%, 2.0%,	Pepto Bismol (or generic equivalent)
Benadryl (or generic equivalent) 25mg	Hydrogen Peroxide	Sterile Saline Solution
Betadine Solution (Providone-iodine 10%)	Lotrimin 1%	Tuffskin (Tape Adherent Spray)
Biofreeze (analgesic)	Ibuprofen (generic) 200mg	Tums
Cough Drops (Halls or generic equivalent)	Isopropyl Alcohol	Zinc Oxide Ointment

**Electrolyte Supplement **Phenylephrine HCL 10mg*

The above-named student SHOULD NOT take /is allergic to the following: _____

III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION (HIPAA & FERPA):

I hereby authorize the Sports Medicine Staff (Athletic Trainers and Team Physicians) and School Nurses to share appropriate information (medical and/or other) concerning my child that is relevant to participation in school, activities and athletics with administrators, nurses, counselors, coaches, other healthcare professionals (as determined by parent). I understand that I may revoke this authorization at any time. However, the revocation will not apply to information that has already been released. I understand that I must do any revocation in writing and present my written revocation to the Sports Medicine Staff. Unless revoked, this authorization is in effect for the entire school year.

IV. STATEMENT CONCERNING TRANSPORTATION:

I understand when Archbishop Curley High School does not provide bus or van transportation; my child will be responsible for arranging his/her own means. I do not hold Archbishop Curley High School or its faculty or staff responsible for any problems that may arise from these personal transportation arrangements.

V. STATEMENT OF RISK:

I acknowledge that Archbishop Curley High School assumes no responsibility for any risks associated with voluntary participation in school organized athletic, physical education or other activities. Furthermore, I understand that these sports activities involve risk of serious injury or death. After weighing these risks against the potential benefits my son/daughter may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

VI. STATEMENT OF LIABILITY:

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse or my child, against Archbishop Curley High School and its employees arising from a sports related injury or from transportation to/from a sporting event.

Additionally, Archbishop Curley High School's certified athletic trainers and administrators reserve the right to make final decisions regarding a student-athletes participation status with interscholastic athletics.

By signing below I/we certify that: I/we are in agreement with the statements/authorizations made above, the answers to the questions are true and correct and that I/we understand that having passed the physical examination does not necessarily mean that my child is physically qualified to engage in athletics but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

MEDICAL: PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY PHYSICIAN

NAME: _____ **D.O.B.:** _____ **Grade:** _____ **Sport(s):**_____

1. **MEDICAL CONDITION: Does the child have a *diagnosed* medical condition?** ☐ **YES** ☐ **NO**
   (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, other). Specify:_____
   _____

2. **If YES does the condition require EMERGENCY ACTION while he/she is at school or athletic activities?** Please describe necessary actions or indicators for condition.
   _____

3. ***SICKLE CELL*: Has this individual been tested for *SICKLE CELL*?** ☐ **YES** ☐ **NO** Date: _____
   IF YES please indicate the results: ☐ NEGATIVE ☐ POSITIVE ☐ POSITIVE TRAIT

4. **Is the child on regular medication?** ☐ **YES** ☐ **NO**
   IF YES – Name of Medication(s) - _____

5. **Date of most recent *TETANUS* immunization:** _____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **Vision** ____/__20__

GENERAL MEDICAL	WNL	Abnormal
General Appearance		
Skin		
E N T		
Dental		
Lymph Nodes		
Chest		
Heart/Cardiac		
Lungs		
Abdomen		
Hernias		
Endrocrine		
Other		

MUSCULOSKELETAL	WNL	Abnormal
Spine (Neck/Back)		
Shoulders		
Arms / Elbow		
Elbows		
Hands/Wrists		
Hips		
Legs		
Knees		
Ankles		
Feet		
Neurological/Sensory		
Other		

HEALTH AREA CONCERN	WNL	Abnormal
ADD / ADHD		
Behavior/Adjustment		
Psycholsocial		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Nutrition		
GI / GU		
Speech/Language		
Other		

REMARKS: (Please explain any abnormal findings/health concerns or other medical issues that the health staff need to be aware of)

☐ **CLEARED FOR ALL PHYSICAL ACTIVITY**

☐ **NOT CLEARED - REASON**: _____

Note, should the above named individual have any restrictions, a letter from the individual's physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. Archbishop Curley High School reserves the right to make final decisions as to the above named individual's status regarding participation in interscholastic athletics for Archbishop Curley High School.

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities.

_____ _____ _____
Examiner Name (Print or Type) Examiner Signature DATE

_____ _____
Address Street Telephone Number

_____
City State Zip

If the Physician's Assistant or Nurse Practitioner performed exam, please give the Name & Address of collaborating physician/group