Student Athlete
Health Forms

Name_____ Date_____
LAST FIRST MIDDLE INITIAL

Home Address: _____
(STREET) (CITY) (STATE) (ZIP CODE)

Student cell phone _____ Email address:_____

Social Security Number _____ -_____ - _____ Year in school (circle): FR SO JR SR

MEDICAL HISTORY

1. Do you have or have you ever had any of the following? If so, please include pertinent date(s).

ADHD	Yes____ No ____	Heart disease	Yes____ No____
Allergies	Yes____ No____	Hypertension	Yes____ No____
Asthma	Yes____ No ____	Surgery	Yes____ No____
Cancer	Yes____ No____	Mononucleosis	Yes____ No____
Diabetes	Yes____ No____	Seizure Disorder	Yes____ No____
Eating disorder	Yes____ No____	Other	Yes____No ____

If yes, explain: _____

_____

2. Have you ever received professional help for an emotional or psychological problem? Yes_____ No____

If yes, explain: _____

Name of Therapist/Psychiatrist_____Phone_____

3. Do you have any physical impairment such as paralysis, vision loss, hearing loss? Yes____ No____

If yes, explain _____

4. Are you currently taking any medication? Yes____ No____ If yes, explain _____

_____

5. Are you allergic to any medication? Yes____ No____ If yes, explain_____

_____

FAMILY HISTORY: is there a history within your primary family (parents and siblings) of

Cancer	Yes____ No____	Diabetes	Yes____ No____ Other _____
Heart Disease	Yes____ No____	Asthma	Yes____ No____

If yes, explain_____

_____

EMERGENCY CONTACT INFORMATION:
Please list both parents, if available, and an additional adult in case parents cannot be reached.

_____ Name	_____ Name	_____ Name
_____ Relationship	_____ Relationship	_____ Relationship
(_____)_____ Home #	(_____)_____ Home #	(_____)_____ Home #
(_____)_____ Work #	(_____)_____ Work #	(_____)_____ Work #
(_____)_____ Cell #	(_____)_____ Cell #	(_____)_____ Cell #

Student Athlete
Health Forms

Name_____Date_____
LAST FIRST MIDDLE INITIAL

CWID#_____ Date of Birth:_____

Pre-participation Physical Evaluation HISTORY FORM

SPORT _____

Explain "Yes" answers below
Circle questions you don't know the answers to.

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?
4. Do you have allergies to medicines, pollens, foods, or stinging insects?
5. Have you ever passed out or nearly passed out DURING exercise?
6. Have you ever passed out or nearly passed out AFTER exercise?
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?
8. Does your heart race or skip beats during exercise?
9. Has a doctor ever told you that you have (check all that apply):
   High blood pressure
   High Cholesterol
   A heart murmur
   A heart infection
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
11. Has anyone in your family died for no apparent reason?
12. Does anyone in your family have a heart problem?
13. Has any family member or relative died of heart problems or of sudden death before age 50?
14. Does anyone in your family have Marfan syndrome?
15. Have you ever spent the night in a hospital?
16. Have you ever had surgery?
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game?
    If yes, circle affected area below:
18. Have you had any broken or fractured bones or dislocated joints?
    If yes, circle below:
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:
20. Have you ever had a stress fracture?
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
22. Do you regularly use a brace or assistive device?
23. Has a doctor ever told you that you have asthma or allergies?
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?
25. Is there anyone in your family who has asthma?
26. Have you ever used an inhaler or taken asthma medicine?
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
28. Have you had infectious mononucleosis (mono) within the last month?
29. Do you have any rashes, pressure sores, or other skin problems?
30. Have you had a herpes skin infection?
31. Have you ever had a head injury or concussion?
32. Have you been hit in the head and been confused or lost your memory?
33. Have you ever had a seizure?
34. Do you have headaches with exercise?
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
36. Have you ever been unable to move your arms or legs after being hit or falling?
37. When exercising in the heat, do you have severe muscle cramps or become ill?
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
39. Have you had any problems with your eyes or vision?
40. Do you wear glasses or contact lenses?
41. Do you wear protective eyewear, such as goggles or a face shield?
42. Are you happy with your weight?
43. Are you trying to gain or lose weight?
44. Has anyone recommended you change your weight or eating habits?
45. Do you limit or carefully control what you eat?
46. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

47. Have you ever had a menstrual period?
48. How old were you when you had your first menstrual period?
49. How many periods have you had in the last 12 months?

EXPLAIN "Yes" answers here:

_____

_____

_____

Questions on More Sensitive Issues

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tired cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   Notes:

Student Athlete
Health Forms

Name_____Date_____
LAST FIRST MIDDLE INITIAL

CWID#_____ Date of Birth:_____

Pre-Participation Physical Evaluation **PHYSICAL EXAMINATION FORM**

Height Weight %Body fat (optional) Pulse BP

Viision R 20/ L 20/ Corrected: Y N Pupils: Equal Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulse			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

EMERGENCY INFORMATION

Allergies

Other Information

IMMUNIZATIONS Up to date Not up to date (Specify)

Please include copy of Vaccine Administration Record.

CLEARANCE DETERMINATION (please use additional page if needed)

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for
- Not cleared for ____ Any sports ____ Certain sports: _____
  - Reason _____
  - Recommendations _____

Name of physician (print/type) **Date of exam**

Address **Phone**

Signature of physician **MD or DO**

INSURANCE INFORMATION

Name_____Date_____
LAST FIRST MIDDLE INITIAL

CWID#_____ Date of Birth:_____

IF YOU HAVE COVERAGE OTHER THAN THE MARIST COLLEGE STUDENT ACCIDENT AND SICKNESS PLAN,
PLEASE COPY THE FRONT OF YOUR HEALTH INSURANCE CARD HERE
(OR INSERT ANOTHER PAGE WITH A COPY OF THE FRONT OF THAT CARD)

IF YOU HAVE COVERAGE OTHER THAN THE MARIST COLLEGE STUDENT ACCIDENT AND SICKNESS PLAN,
PLEASE COPY THE BACK OF YOUR HEALTH INSURANCE CARD HERE
(OR INSERT ANOTHER PAGE WITH A COPY OF THE BACK OF THAT CARD)

LABORATORY TESTING
Marist Health Services has contracts for courier pick-up with three providers of laboratory services, Quest Lab, Lab Corp and the Center for Disease Detection. The Marist Accident and Sickness Insurance Plan uses Lab Corps as a preferred provider. We will use or refer to the preferred provider whenever possible. **Please list the preferred Laboratory Service provider for your insurance:**

Student Athlete
Health Forms

Name_____Date_____
LAST FIRST MIDDLE INITIAL

CWID#_____ Date of Birth:_____

NCAA Mandated Sickle Cell Trait Testing

The Division I Legislative Council of the National Collegiate Athletic Association (NCAA) has reuled that all incoming Division I student athletes must be tested for Sickle Cell Trait (SCT), show proof of a prior test, or sign a waiver releasing an institution from liability if the student athlete declines to be tested.

While any person may have SCT, individuals at high risk are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia, and Caribbean and Mediterranean countries.
The goal of Marist College Athletics is to provide the highest level of safety for all student athletes. Please see the FACT SHEET ON SICKLE CELL TRAIT for more information.

Marist college students will not be allowed to try out for any NCAA Division I team or participate in any practice or game until the Athletic Training Department receives

1. **The results of a Sickle Cell Trait test**
   - If your doctor has the result of a test in infancy or childhood, you can request that it be sent to the address below. This may take several weeks, so we recommend requesting the result as soon as possible. We recommend that you keep a copy of your test for your own records.

   ----------OR----------

2. **A signed Waiver of Sickle Cell Trait Testing** (below) stating that you have read the Fact Sheet on Sickle Cell Trait but decline to be tested

Please read the FACT SHEET ON SICKLE CELL TRAIT at http://www.marist.edu/healthservices/pdfs/sicklecell.pdf, complete the section below, and include this form with the rest of the Health Forms sent to the Athletic Training Department

---

____ **I have been tested for Sickle Cell Trait and include or will mail a copy of my results.**
(Forms must be received by July 15 or as soon as possible for late admissions.)

____ **I agree to be tested for Sickle Cell Trait.** I wish to have the test at Marist College
I understand that this will be at my expense and will delay athletic participation.

_____

Signature Date

Waiver of Sickle Cell Trait Testing

____ I do not wish to have Sickle Cell Trait Testing performed. I understand the information provided about Sickle Cell Trait as well as the recommendation of the NCAA and Marist College that testing be performed on all student athletes.

Signature (of parent or guardian if student is under 18 years of age) Date

---

Name of parent or guardian (if signing above)