



**Campus Recreation  
Annual Health Update**  
*Please Print Legibly*

Athlete's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_  
 Local Address: \_\_\_\_\_ Local Phone Number: \_\_\_\_\_  
 Club Sport: \_\_\_\_\_

**Medical History:** Explain "YES" answers in the space provided below. Circle questions you don't know answers to.

	YES	NO		YES	NO
1. Have you had a medical illness since your last check up or sports physical?	___	___	16. Do you have asthma?	___	___
2. Do you have any ongoing chronic illness?	___	___	17. Do you use any protective equipment that aren't usually used for your sport position (ie. knee brace, foot orthotics, hearing aid, retainer)?	___	___
3. Have you ever had surgery?	___	___	18. Do you wear glasses, contacts or protective eyewear?	___	___
4. Are you currently taking any prescription or non prescription medications drugs or inhalers?	___	___	19. Have you ever had a sprain, strain or swelling after injury?	___	___
5. Have you ever taken supplements or vitamins To help you gain or lose weight or improve Performance?	___	___	20. Have you broken or fractured any bones or dislocated any joints?	___	___
6. Do you have any allergies (ie. pollen, food medicine, or insects)?	___	___	21. Have you ever had any problems with pain, swelling in muscles, tendons, bones or joints?	___	___
7. Have you passed out during or after exercise	___	___	<i>If yes, check appropriate blank and explain below</i>		
8. Have you ever had chest pain during or after exercise?	___	___	___Head	___Elbow	___Hip
9. Have you had high blood pressure or high cholesterol?	___	___	___Neck	___Forearm	___Thigh
10. Have you ever had a head injury or concussion?	___	___	___Chest	___Wrist/Hand	___Knee
11. Have you ever been knocked out, become unconscious or lost your memory?	___	___	___Shoulder	___Finger	___Ankle
12. Have you ever had a seizure?	___	___	___Upper Arm	___Back	___Foot
13. Have you ever had a stinger, burner or pinched nerve?	___	___	22. Has any relative had sudden death or Marfan's syndrome?	___	___
14. Do you cough, wheeze or have trouble breathing during or after exercise?	___	___	23. Do you want to weight more or less than you do now?	___	___
15. Have you ever had irregular heartbeats or palpitations?	___	___	24. Do you regularly exercise? How often? _____	___	___

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Athlete/Patient Consent for Release Information**

I hereby certify that the answers to the above questions are true, correct and include all pertinent medical information. I hereby authorize the release of the above information to Director of Campus Recreation and to the Associate Dean of Student and Community life.

Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If athlete is under the age of 18:

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Re-release of medical information by recipient is prohibited unless duly authorized by the athlete/patient.

*For ATC use ONLY:*

ATC Reviewed: _____	Date: _____
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