

The information contained in this medical history form will only be used by the Team Saskatchewan Softball Mission Staff for purposes of determining if you pose a health threat/risk to yourself on the athletic field and to review your past medical history in the event of a new emergency or re-occurrence. Please fill this form out with your parent/guardians knowledge and/or assistance. The form will stay in a file that will remain with the team at all times. This information will remain confidential at all times.

Please print clearly in BLUE or BLACK ink only! Pencil is not acceptable.

A. General Information

Name _____ Date _____

SK HEALTH NUMBER: _____

Date of Birth _____ Sport _____ Age Category _____

PERMANENT ADDRESS:

_____ STREET
 _____ CITY STATE ZIP CODE

Home Phone: (_____) _____ Cellular Phone: (_____) _____

IN CASE OF EMERGENCY CONTACT

Home Phone: (_____) _____ Cellular Phone: (_____) _____

Relation to athlete _____

IN CASE OF EMERGENCY CONTACT #2

Home Phone: (_____) _____ Cellular Phone: (_____) _____

Relation to athlete _____

B. Medical Questions

If you answer **yes** to any of the following questions, please provide an explanation at the end of this section or on a separate sheet of paper.

Please remember, all answers to the questions will remain confidential.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Have you ever had chest pain and/or shortness of breath, dizziness, lightheadedness, or passed out during or after exercise/practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you get tired more quickly than your teammates/friends do during exercise/practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Have you ever been told that you have a heart murmur? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Has any family member or close relative had heart problems and/or died of sudden death before the age of 50? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Does anyone in your family have a history of high blood pressure or high cholesterol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever been diagnosed with seasonal allergies? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Are you presently taking or have you previously taken any allergy medications? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications, food, insect bites, or bee stings? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Have you ever been diagnosed with asthma and/or exercised-induced asthma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Are you presently taking or have you previously taken any asthma medications or used an inhaler? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Date(s) _____

Please describe _____

14. If yes, then how many times do you use your rescue inhaler (e.g., Albuterol, Proventil, etc.) during an average week? _____

15. If yes, then how many acute asthma attacks have you had in the past 12 months? _____

16. Have you ever suffered a head injury/concussion (no matter how minor)? YES NO

17. List date(s)/time(s) (e.g., practices or games) missed _____
18. Do you suffer from headaches? YES NO How often? Every Day 1-2 Times/Week 1-2 Times/Month
19. Where are your headaches located? Left Side of Head Right Side of Head Front of Head Back of Head All Over Head
20. Do you have a history of migraine headaches? YES NO
21. When was your last eye exam? _____
22. Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? YES NO
23. Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? YES NO
24. Do you routinely wear glasses? YES NO
25. Do you routinely wear contact lenses? YES NO Type _____
26. Do you require any special hearing devices/equipment? YES NO Type _____
27. Have you ever suffered an injury to your ear(s), nose, and/or throat? YES NO
28. Have you ever suffered an injury to your mouth, jaw, and/or teeth? YES NO
29. Have you ever suffered an injury to your cervical spine and/or neck? YES NO
30. Have you ever had "burners," "stingers," or brachial plexus injuries? YES NO
31. Have you ever experienced numbness and/or tingling in your arms/fingers? YES NO
32. Have you ever suffered an injury to your shoulder/upper arm? YES NO
33. Have you ever suffered an injury to your elbow/forearm? YES NO
34. Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)? YES NO
35. Have you ever suffered an injury to your spine/low back/sacroiliac joint? YES NO
36. Have you ever had numbness/tingling down one or both legs? YES NO
37. Have you ever suffered an injury to your hip/groin (including hernias and/or sorts hernias)? YES NO
38. Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? YES NO
39. Have you ever suffered an injury to your knee and/or patella (kneecap)? YES NO
40. Have you ever or do you presently wear a knee brace? YES NO
- Which knee? _____ Brand/Model of brace? _____
- Reason for wearing? _____
41. Have you ever suffered an injury to your ankle/lower leg/feet/toes? YES NO
42. Do you presently tape your ankle(s) use ankle brace(s) Other. Please describe _____
43. Have you ever suffered an injury to your rib/thorax/chest? YES NO
44. Have you ever been diagnosed with a problem with your stomach, abdomen, intestines, or rectum? YES NO
45. Do you routinely suffer from severe or recurrent abdominal pain? YES NO
46. Do you routinely suffer from chronic or recurrent diarrhea? YES NO
47. Do you have only one of two paired, functioning organs (e.g., kidney, testicles, ovary)? YES NO
48. Have you ever been diagnosed with a communicable disease (Tuberculosis)? YES NO
49. Do you have any skin problems that we should be aware of (e.g., itching, rashes, acne, warts, eczema, fungus)? YES NO
50. Have you ever suffered from a heat-related illness? YES NO
- a. (check all that apply): heat cramps/heat syncope (fainting) heat exhaustion heat stroke
51. Have you ever received intravenous fluids (IV) or been hospitalized for a heat-related problem? YES NO
52. Have you ever been diagnosed with Diabetes? YES NO
53. If yes, do you daily monitor your blood sugar level? YES NO
- How many times per day? _____ What is your average level? _____
54. Have you had your A1C level checked within the last three (3) months? YES NO
55. Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months? YES NO
56. Have you ever, to the best of your knowledge, been tested for Sickle Cell Anemia? YES NO
57. Does any member of your family, to the best of your knowledge, carry the Sickle Cell Trait/have Sickle Cell Anemia? YES NO
58. Have you ever been advised that you carry the Sickle Cell Trait/have Sickle Cell Anemia? YES NO
59. Have you ever had any injury or illness other than those already noted? YES NO
60. Do you have any ongoing or chronic illnesses? YES NO
61. Have you ever been told by a physician to restrict your sports activity or not to participate in a sport? YES NO
62. Have you ever been under the care of a psychiatrist and/or psychologist? YES NO
63. Have you ever had a rash or hives develop during and/or after exercise? YES NO

- 64. Have you ever been told that you have kidney disease? YES NO
- 65. Have you ever had Rubella (German Measles) and/or Rubeola (Red Measles) or Chicken Pox? YES NO
- 66. Have you ever had a stomach and/or duodenal ulcer? YES NO
- 67. Have you had a viral infection (i.e., mononucleosis, myocarditis) within the past six (6) months? YES NO
- 68. Have you ever had seizures, convulsions, and/or epilepsy? YES NO
- 69. Have you ever had gallbladder disease and/or a urinary problem? YES NO
- 70. Do you have frequent ear infections or nosebleeds? YES NO
- 71. Have you had a tetanus booster within the past five (5) years? If yes, when? _____ YES NO
- 72. Have you ever received the Hepatitis B (HBV) vaccination series (all 3 shots)? If yes, when? _____ YES NO
- 73. Have you had a weight change (loss or gain) of greater than 10 pounds in the past year? YES NO
- 74. What is your ideal weight? _____
- 75. Are you a vegetarian? If yes, what _____ YES NO
- 76. Do you regularly lose weight to participate in your sport? YES NO
- 77. Do you want to weigh more or less than you presently do? YES NO
- 78. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders? YES NO

For Females Only

- 80. Have you had menstrual periods within the past 12 months? YES NO
 - If yes, how many? _____ When was your most recent menstrual period? _____
 - How much time do you usually have from the start of one period to the start of another? _____
 - What was the longest time between menstrual periods within the past year? _____
- 81. Do you have painful or heavy menstrual periods? YES NO
- 82. Do you take any medications during your menstrual periods? If yes, what? _____ YES NO
- 83. Do take birth control pills? If yes, what brand? _____ YES NO
- 84. Have you ever had any problems with your breasts? YES NO
- 85. Have you had a pelvic examination within the last year? YES NO
- 86. Are you presently pregnant ? YES NO
- 87. Have you been pregnant and given birth in the last year? YES NO

For Males Only

- 88. Have you ever had a testicular examination? Date _____ YES NO
- 89. Have you ever been diagnosed with testicular cancer? YES NO

Answers

If you have answered yes to any of the above, please explain: _____

Prescription/Non-Prescription Medications and Supplements:

Please list all prescription, over-the-counter, non-prescription medications and supplements you are currently taking and for what purpose.

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

Catastrophic Injury Statement

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I understand that by participating in Team Saskatchewan – NAIG athletics the potential for a catastrophic injury does exist. With this fact in mind, I understand the importance of the rules and the procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though I follow all instruction as to proper technique. I understand that a physicians assessment may eliminate me from further participation due to an injury, illness, or medical condition which could represent a risk to my safety.

Athlete's Signature: _____ Date: _____

Medical History Statement

I have completed this medical history questionnaire and answered it to the best of my knowledge and truthfully. I am prepared to answer questions from the Team SK medical and mission staff (including athletic trainers, nurses, consultants, coaches, and coordinators) and general practitioners concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have **not disclosed** on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to Team SK –NAIG 2008 as it may be a matter of life or death.

Athlete's Signature: _____ Date: _____

Authorization to Treat/Authorization to Release Information

I give authorization to the athletic training staff, physicians, health services, and the medical consultants of NAIG 2008 and Team SK to evaluate and treat any injuries that may occur during my participation in training camps, competition, practices and the North American Indigenous Games 2008. I also give authorization to the athletic training staff to make referrals for treatment to the physicians and/or other medical consultants of NAIG 2008 and Team SK. I give authorization to the athletic training staff, coaches and coordinators to communicate with the physicians, health services, and medical consultants of NAIG 2008 and Team SK about any injuries and inform my parent/guardian(s) as to the nature of my injury(ies), limitations, and estimated time of return. Finally, I give authorization to coaching, coordinating and mission staff to hold this emergency information as to my medical history (i.e., allergies, conditions, etc.) and insurance information which would be considered important for health care staff to have if I were in an accident and unable to give this information. I understand that this authorization is valid for one calendar year and that any or all of it may be revoked by me at any time by doing so in writing.

Athletes Signature: _____ Date: _____

