

HINSDALE SCHOOL DISTRICT

Sports Pre-Participation History Form

Grade: _____ School Year: _____ Age: _____ Sport: _____

Name: _____ Date of birth: _____ Sex: _____

Parent(s)/Guardian(s): _____

Address: _____ City: _____ Zip code: _____

Home Phone: _____ Work Phone (Mother or Father – circle one): _____

Contact if Parent(s) cannot be reached: _____ Phone: _____

Family Physician: _____ Phone: _____

Emergency Hospital: _____ Health Insurance Company: _____

THIS FORM IS TO BE COMPLETED BY A PARENT/GUARDIAN

Please explain any "Yes" answers on the next page:	Yes	No
1. Has your child had a medical illness or injury since their last check-up or sport physical?		
2. Has your child ever been diagnosed with an ongoing or chronic illness (i.e., diabetes, rheumatic fever, hepatitis etc.)?		
3. Has your child ever had surgery or been hospitalized overnight?		
4. Is your child presently taking any prescription medications or using an inhaler?		
5. Is your child allergic to medicine, food, or stinging insects?		
6. Have your child's allergic reactions gotten worse?		
7. Have seasonal allergies required treatment?		
8. Has your child ever had trouble swallowing after an allergic reaction?		
9. Has your child ever passed out or been dizzy during or after exercise?		
10. Has your child ever had chest pain during or after exercise?		
11. Has your child ever had racing of their heart or skipped heart beats?		
12. Has your child ever had high blood pressure or high cholesterol?		
13. Has your child been told they have a heart murmur?		
14. Has any family member or relative died of heart problems or of sudden death before the age of 50?		
15. Has your child had a severe viral infection (i.e., mononucleosis) within the last month?		
16. Has a physician ever restricted your child's participation in sports for any heart-related problem?		
17. Has your child become ill from exercising in the heat?		
18. Has your child ever been diagnosed with asthma?		
19. Does your child or anyone in your family have sickle cell trait or disease?		
20. Does your child use any special protective or corrective equipment or devices that aren't usually used for their sport or position (i.e., knee brace, orthotics, braces)?		
21. Does your child have any problem with their eyes?		
22. Does your child wear contacts or glasses while playing?		
23. Has your child ever broken or fractured any bones or dislocated any joints?		
24. Has your child ever had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check the appropriate box and explain below:		
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> Knee <input type="checkbox"/> Neck <input type="checkbox"/> Upper Arm <input type="checkbox"/> Finger <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Foot		

Please explain any "Yes" answers below:	Yes	No
25. Has your child ever had a head injury or concussion?		
26. Has your child ever been knocked out, lost their memory, or become unconscious?		
27. Has your child ever had a seizure?		
28. Does your child have frequent headaches?		
29. Has your child ever had numbness or tingling in their arms, hands, legs or feet?		
30. Has your child ever had a stinger or pinched nerve?		
31. Does your daughter have any menstrual problems?		
32. Does your child have any hearing problems?		
33. Is your child missing a kidney, testicle or ovary?		

Explanations for any "YES" answers (please include dates): _____

Please list the dates of your most recent immunizations for:

Tetanus _____ Measles _____ Hepatitis _____ Chickenpox _____

Parental Consent for Treatment/Care:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I hereby give my permission to employees of the Hinsdale School District, athletic trainers, team physician, school nurse, administration or designee and EMS services to provide whatever treatment/care is deemed necessary in case of injury. I am aware that I will be responsible for any bills that result from the above treatment/care.

Parent/Guardian Signature

Date

Student Signature

Date