

Sport _____ Date _____

Tyler Junior College Intercollegiate Athletics
Medical History Form

Name Last _____ First _____ Middle _____

SSN _____ - _____ - _____ DOB _____ / _____ / _____ Age _____ Sex _____

Local Address _____ Local Phone #(_____) _____

Apt.# _____ City _____ State _____ Zip _____

Mother/Guardian _____ Home Phone #(_____) _____

DOB _____ / _____ / _____ Work Phone #(_____) _____

Father/Guardian _____ Home Phone #(_____) _____

DOB _____ / _____ / _____ Work Phone #(_____) _____

Permanent Address _____

Apt. # _____ City _____ State _____ Zip _____

1. Have you had a medical illness, injury, or surgery since your last check up or sports physical? Yes No

Describe _____

2. Have you ever been hospitalized overnight? Yes No

If yes, for what _____

3. Do you currently have any ongoing chronic illness? Yes No

Describe _____

4. Have you ever had surgery? Yes No

Describe _____

5. Are you currently taking any prescription or nonprescription(over-the-counter) medications, pills, or inhalers? Yes No

List _____

6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve performance? Yes No

List _____

7. Do you have any known allergies to environmental agents, medications, foods, or insects? Yes No

List _____

8. Have you been diagnosed with a severe viral infection (i.e. mononucleosis) within the last month? Yes No

Describe _____

9. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No

10. Do you have asthma? Yes No

If yes, what medications are you taking? _____

11. Have you ever passed out during or after exercise? Yes No

12. Have you ever felt dizzy during or after exercise? Yes No

Describe _____

13. Have you ever suffered from heat cramps, heat exhaustion, or heat stroke? Yes No

Describe _____

14. Have you ever had a rash or hives develop during or after exercise? Yes No

15. Do you have any current skin problems? (i.e. rashes, acne, itching, warts, fungus, blisters) Yes No

Describe _____

16. Have you had any problems with your eyes or vision? Yes No

17. Do you wear glasses, contacts, or protective eyewear? Yes No

Describe _____

18. Were you born with a complete set of paired organs? (i.e. eyes, ears, kidneys, ovaries, testicles, lungs) Yes No

If not, which organs _____

19. Have you ever had surgery to repair or remove an organ? (i.e. hernia, tonsils, appendix, spleen) Yes No

Describe _____

20. Have you ever been diagnosed as being iron deficient or suffered from uncontrollable bleeding? Yes No

21. Have you or any of your family members ever been diagnosed with sickle cell trait? Yes No

If yes, which member? Mother____ Father____ Brother____ Sister____ Grandmother ____ Grandfather____ Aunts/Uncles____

22. Have you ever experienced chest pains before, during, or after exercise? Yes No

Describe _____

23. Do you get tired more quickly than your friends do during exercise? Yes No

24. Have you ever been diagnosed with and irregular heartbeat? Yes No

25. Have you ever been diagnosed with high blood pressure or high cholesterol? Yes No

26. Have you ever been diagnosed with a heart murmur? Yes No

Describe _____

27. Has any family member or relative died of a heart condition or of sudden death before the age of 50? Yes No

If yes, which member? Mother____ Father____ Brother____ Sister____ Grandmother____ Grandfather____ Aunts/Uncles____

28. Has a physician ever denied or restricted your participation in sports for a heart-related problem? Yes No

Describe _____

29. Have you ever suffered a head injury or concussion? Yes No

30. Have you ever been knocked out, become unconscious, or lost memory? Yes No

Describe _____

31. Have you ever had a seizure? Yes No

32. Do you have frequent or severe headaches? (i.e. migraines) Yes No

Describe _____

33. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No

34. Have you ever had a burner, stinger, or pinched nerve? Yes No

Describe _____

35. Have you ever fractured any bones or dislocated any joints? Yes No

Describe _____

36. Have you ever sprained or torn ligaments to any joint? Yes No

Describe _____

37. Have you ever strained or torn any muscles? Yes No

Describe _____

38. Have you ever had tendonitis, bursitis, or Osgood Schlatter's? Yes No

Describe _____

39. Do you use any special protective or corrective equipment or devices when competing in athletics? Yes No

Describe _____

40. Are there any additional health problems you would prefer to discuss privately with our team physician? Yes No

Females Only – confidential

41. When was your first menstrual period? _____

42. When was your most recent menstrual period? _____

43. How much time do you usually have from the start of one period to the start of another? _____

44. How many periods have you had in the last year? _____

45. Are you currently taking any form of birth control medication? Yes No

If yes, describe _____

The undersigned, herewith,

- A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Certifies the answers to these questions are correct and true.
- C. Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find medical reason to disqualify him/her.
- D. Fully realizes the Tyler Junior College Athletic Department cannot be held responsible to any previous medical condition(s) that he/she might have.

Signature _____

Date _____

PREPARTICIPATION PHYSICAL EVALUATION

Name _____ **Date of Birth** _____
Height _____ **Weight** _____ **% Body fat (optional)** _____
Pulse _____ **BP** _____/_____/_____ (_____/_____, ____/_____)
Vision: R 20/_____ **L 20/**_____ **Corrected: Y N** **Pupils: Equal**_____ **Unequal**_____

	NORMAL	ABNORMAL FINDINGS	INITIAL
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MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

- Cleared
 Cleared after completing evaluation/rehabilitation for: _____

NOT Cleared for: _____ Reason: _____

Recommendations: _____

Signature of Physician _____, MD or DO

Date _____

**Tyler Junior College Department of Athletics
Medical Waiver Form**

Physical Exam and Medical History Waiver

I have had a complete physical examination on ____/____-/_____. I have completed a Medical History Questionnaire to the best of my knowledge and have discussed with the TJC team physicians and/or consultants my prior medical history as well as all existing complaints, injuries, ailments and symptoms. I also affirm that I do not suffer from any disability, injury, condition, complaint, or problem that I have NOT DISCLOSED on any such forms and/or have not discussed with team physicians and/or consultants. Also, I recognize the importance of fully and accurately disclosing my physical condition, past and present, with the Tyler Junior College medical staff and/or consultants.

Date: _____ Signature: _____

Release of Medical Records Waiver

I, _____, give authorization to the head athletic trainer at Tyler Junior College and/or the team physician to release complete copies of my medical records including physicals, injury records, treatment and rehabilitation records, prognosis, and diagnosis of any and all injury and ailments, past and present, to any four year schools medical staff in which you are interested in transferring following your two years at TJC.

Date: _____ Signature: _____

Catastrophic Injury Waiver

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I, _____, understand that by participating in athletics at Tyler Junior College the potential of a catastrophic injury does exist. With this fact in mind, I understand the importance of rules and procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though the above are followed to the fullest.

Date: _____ Signature: _____

Authorization to Treat and Care

I give authorization to the athletic training staff and/or medical consultants to evaluate and treat any injuries at Tyler Junior College. I understand the team physician has the authority to eliminate me from further participation because of an injury and/or because of an undue liability risk to Tyler Junior College.

Date: _____ Signature: _____

Acknowledgement of Receipt of Drug Testing Program at Tyler Junior College and Agreement to Abide by the Terms and Conditions Contained Therein

I hereby acknowledge that I have received a copy of the Tyler Junior College Drug Education, Testing, and Counseling Program. I further acknowledge that I have read said program and that I fully understand the provisions of the program and agree to abide by the terms and conditions contained therein as a condition for participating in intercollegiate athletics at Tyler Junior College.

Date: _____ Signature: _____

Consent to Testing of Urine Sample and Authorization for Release of Information

I hereby consent to have samples of my urine collected and tested for the presence of certain drugs or substances in accordance with the provisions of the Tyler Junior College Drug Education, Testing, and Counseling Program, at all times urinalysis testing is required under the program during the academic year. Furthermore, I understand that these drug screenings may be random in its selection and irregular in application, and will occur at times in addition to the complete physical examination.

I further authorize the personnel conducting the test to make a confidential release to the Dean of Health, Physical Education, Recreation and Athletics and any other individuals authorized, of test results and information relating to the screening or testing of my urine sample(s) in accordance with the provisions of the Tyler Junior College Drug Education, Testing, and Counseling Program. I further authorize this information to be released under the Family Educational Rights and Privacy Act.

Tyler Junior College, its Board of Trustees, its administrators, employees, and agents are hereby released from legal responsibility of liability for the release of such information and records as authorized by this form.

Date: _____ Signature: _____

For Football Use Only

Warning: Do Not use this Helmet to butt, ram or spear an opposing player. This is in violation of the football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent. No helmet can prevent all head or neck injuries a player might receive while participating in football.

The above statement has been provided so that you the athlete can be aware of the possible dangers and catastrophic injuries that may occur while participating in football. By signing this statement, you agree that you understand any complications that may arise while participating in Intercollegiate Football for Tyler Junior College.

Date: _____ **Signature:** _____

Sport _____

**Tyler Junior College Department of Athletics
Medical Insurance Information Form**

Please return the completed form in the envelope provided and also include copies of insurance cards for medical, dental, or prescription. If you cannot get a copy, please send the original and we will make a copy and return the original to you.

Health Insurance

Athlete Name _____ Social Security # _____

Name of Insured Party _____ Social Security # _____

Insurance Company _____

Insurance Address _____

City _____ State _____ Zip _____

Policy # _____ Group # _____

Insurance Phone Number _____

Dental Insurance

Do you have a policy to cover dental work on the above listed athlete? Yes _____ No _____

Insurance Company _____

Insurance Address _____

City _____ State _____ Zip _____

Policy # _____ Group # _____

Insurance Phone Number _____

Authorization

I Hereby Authorize:

1. Tyler Junior College Athletic Department to release the above information as well as release any medical information needed to process a claim in their benefit for my son's/daughter's medical expenses with my insurance company.
2. The payment of medical benefits by my insurance company will be made to the physicians or supplier for services rendered.

Parent Signature _____ Date _____