

2009-10 Grand Canyon University Student Athlete Health Report

Please Print

Name _____ Date _____

 Last First Middle Sport _____ Male Female Birthdate ____/____/____ Age _____

Social Security # _____ Marital Status Married Single Year in School _____

Local Address _____

Local Phone # _____ Mobile Phone # _____

Pager # _____ Work Phone # _____ email _____

Permanent (Home) Address _____

Father's Name _____ Work Phone # _____

Address _____ Home Phone # _____

Mother's Name _____ Work Phone # _____

Address _____ Home Phone # _____

EMERGENCY INFORMATION

Allergies: _____

Medical Conditions: _____

Medication Currently Taking: _____

In case of Emergency Notify: _____

Relationship: _____

Address _____ City, State, Zip _____

Home Phone # _____ Work phone # _____ Mobile phone # _____

ATHLETIC INSURANCE PROFILE

Personal Insurance Carrier _____

Insurance Carrier Address _____

Insurance "Claims" Phone Number _____

Policy Number _____ Group number _____

Policy Owner's Full Name _____ Employer _____

Policy Owner's Social Security # _____

Policy Owner's Address _____

Does your personal insurance carrier require you to go to certain doctors and/or hospitals? Yes No

If yes, please specify _____

**2009-10 PHYSICAL EXAMINATION
TO BE COMPLETED BY PHYSICIAN**

Name of Athlete Examined _____

Height _____ Weight _____ Pulse _____ Blood Pressure (1) _____ (2) _____ Visual Acuity (R) 20/ _____ (L)20/ _____

CLINICAL EXAM: Check each item in appropriate column. Elaborate as needed.

Nor	Abn	
		H.E.E.N.T _____
		Pupil Size _____
		Skin _____
		Heart _____
		Lungs _____
		Abdomen _____
		Hernia and Genitalia (males) _____
		Neurological _____
		Spinal Column (scoliosis, etc.) _____
		Upper Extremities _____
		Lower Extremities _____

COMMENTS AND RECOMMENDATIONS:

RESTRICTIONS:

Physician (PLEASE PRINT)

Physician's Signature

Date

Physician's Address

Phone Number

I agree that the information on this sheet is accurate to my knowledge and have asked questions regarding my health and understand and will follow recommendations and restrictions as described above.

Student-Athlete Signature

Date

GRAND CANYON UNIVERSITY ATHLETIC TRAINING
2009-10 HEALTH HISTORY QUESTIONNAIRE

This information is confidential. Please answer all questions fully and explain all "Yes" answers in the space provided. This form must be completed and returned before the student-athlete will be permitted to practice or compete. Further medical evaluations may be required for specific problems.

Name _____ Date _____

Sport _____ Social Security # _____

GENERAL INFORMATION

1. Please list any prescription or non-prescription medications, supplements or vitamins you are taking on a regular basis (including birth control pills).

2. Please list ALL allergies to medications, environmental substances, adhesives, or any other allergies you may suffer from.

Yes	No	Question:	If yes, please explain:
		Have you ever fainted, felt like fainting or become dizzy either at rest, during, or after exercise?	
		Do you ever get short of breath with or after exercise?	
		Have you ever been told you had a heart murmur, high blood pressure or heart disease?	
		Have you ever had surgery or have been advised to have surgery at any time in your life?	
		Have you ever had chest pain or an irregular heart rhythm at rest or during exercise?	
		Have any blood relatives died before the age of 50 from natural causes (heart disease, cancer, etc.) or unexplained causes?	
		Have you ever had any illness that lasted longer than one week or caused you to miss a practice or a game?	
		Have you ever been hospitalized overnight or longer?	
		Are you currently ill or have you been ill within the past four weeks?	
		Have you had any problems with environmental heat or cold illness?	
		Do you have any history of chest pain, or irregular heart rhythm at rest, during or after exercise?	
		Do you have any loss or impairment of internal organs?	
		Do you have a bleeding disorder (anemia, hemophilia)?	
		Do you think you have problems with your weight or have an eating disorder?	
		Do you have any history of frequent (more than 3x a week) diarrhea or constipation?	
		Do you know of any health reason why you should not participate in Grand Canyon Univ. Intercollegiate Athletics at this time?	
		Have you ever been instructed by a physician to NOT participate in any sport activity?	

Please indicate if you have a history of any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:	Yes	No	Medical Condition:
		Seizures			Tuberculosis			Asthma
		Hepatitis			Mononucleosis			Rheumatic fever
		Abdominal infections			Abdominal trauma			High blood pressure
		Diabetes			Collapsed lung			Arthritis
		Bronchitis			Scarlet fever			Heart murmur
		Pneumonia			Thyroid disease			Other: _____

HEAD AND NECK

Yes	No	Question	If yes, please explain:
		Have you had any head injury, concussion (loss of consciousness, fainting, knockout, blurred vision, "dinged") during the past three (3) years?	
		Do you have abnormal hearing in either ear or abnormal vision in either eye (including color blindness)?	
		Do you wear contacts or glasses?	
		Do you have frequent headaches or headaches after exercise (not related to injury)?	
		Do you have a history of a fracture, injury or pain in the face, jaw, teeth, skull or nose?	
		Do you have any teeth or gum discomfort, broken or missing teeth, or do you wear a removable dental appliance?	
		Have you been advised to have any dental (teeth or gum) surgery, procedure (fillings, caps, crowns, etc) that has not been done?	

ORTHOPEDIC

Yes	No	Question	If yes, please explain:
		Have you ever had a fracture, dislocation, ligamentous, or cartilage injury?	
		Have you been advised to have any orthopedic surgery (bones, joints, ligaments, cartilage or disc) at any time in your life?	

Please indicate if you have had any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:
		Stress fracture			Shoulder impingement
		Chondromalacia			Osteomyelitis
		Osgood-Schlatters Disease			Patellar tendinitis
		"Little league elbow"			Achilles tendinitis
		Shin splints (MTSS)			Burner or stinger
		Rotator cuff tendinitis			Other: _____

FAMILY HISTORY

Yes	No	Question	If yes, please explain:
		Has any blood relative(s) died before the age of 50 from natural causes (heart disease, cancer, etc) or from unexplained causes?	

Please indicate if any **blood relative(s)** (Mother, Father, Sisters, Brothers, Grandparents...) have had any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:	Yes	No	Medical Condition:
		High blood pressure			Asthma			Cancer
		Stroke			Chronic bronchitis			Diabetes
		Heart attack			By-pass surgery			Sickle-cell disease
		Migraine/chronic headaches			Kidney disease			Skin disorders
		Drug/alcohol dependency			Nerve disorders			Intestine disorders
		Other:			Other:			Other:

ADDITIONAL FEMALE HISTORY

Yes	No	Question	If yes, please explain:
		Have you failed to menstruate for more than three (3) consecutive months?	
		Do you have irregular cycles: less than 21 days or more than 35 days?	
		Do you have abnormal menstrual flow: less than 2 days or more than 7 days?	
		Would you like to speak with a health care professional about women's health?	

Please utilize this space for additional responses to "yes" answers.

ALL STUDENT-ATHLETES

The undersigned, herewith:

- A. Understands that he/she must refrain from practice or competition during medical treatment until they are discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Certifies that the answers to these questions are true and correct.
- C. Understands that he/she having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
- D. Fully realizes that Grand Canyon University cannot be held responsible for any previous conditions that he/she might have.
- E. Understands permission to participate will not be granted until these forms are completed and signed by the certified athletic trainer.

Student-athlete's Signature _____ Date _____

If minor:

Parent / Guardian Signature _____ Date _____

Certified Athletic Trainer's Signature _____ Date _____

Grand Canyon University Athletic Training

HEAT ACCLIMATION QUESTIONNAIRE

Name _____ Sport _____ Date _____

Please answer all questions at least with yes or no answers.

1. Have you ever had any type of heat related problem (heat exhaustion, stroke, cramps, dizziness, fainting, collapse) before?
2. If you answered yes to the above question, how many times did that particular problem occur, when did it happen, and did you seek treatment?
3. Were you on any form of conditioning program during the summer? If the answer is yes, briefly explain your program.
4. Did you work or work-out in an air-conditioned building during the summer?
5. Are you presently on a diet or a vegetarian? If yes, what kind of diet? Who designed it?
6. How often do you intake fluids during exercise? Do you consume sports drinks during exercise?
7. Have you recently (last 2 weeks) had a cold, problem with vomiting, or diarrhea? If yes, please explain.
8. Are you currently on any medication? If yes, list the name and/or purpose of the medication.

NOTICE : If you notice any of the following signs of heat illness, during or after activity, seek attention of athletic trainer immediately:

Nausea
Fatigue
Unsteadiness
Weakness
Cramping
Disturbed vision
Decreased sweating
Rapid & weak pulse