MEDICAL HISTORY AND EMERGENCY INFORMATION FORM

Our Savior New American School

This MEDICAL HISTORY FORM must be completed annually by parent (or guardian) and student in order for the student to participated in OSNAS athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event

Name:			
Gender:	Date of Birth:	Age:	Grade:
Street Address:	Town:	State:	Zip:
Home Phone:	Parent Cell Phone:		
Personal Physician:	Physician Phone:		
Physician Street address:	Town:	State:	Zip:

In case of emergency contract:

Name:	Relationship:
Home Phone:	Cell Phone:

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1-2 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician's assistant, chiropractor or nurse practitioner is required before any participation in OSNAS practices, games or matches.

		YES	NO
1.	Have you had a medical illness or injury since your last checkup or sports physical?		
2.	Have you been hospitalized overnight in the past year?		
3.	Have you ever had surgery?		
4.	Have you every passed out during or after exercise?		
5.	Have you ever had chest pain during or after exercise?		
6.	Do you get tired more quickly than your friends during exercise?		
7.	Have you ever experienced racing of your heart or skipped heartbeats?		
8.	Have you ever had high blood pressure?		
9.	Have you ever had high cholesterol?		
10.	Have you ever been told you have a heart murmur?		
11.	Has any family member or relative died of heart problems before age 50?		
12.	Has any family member or relative died of sudden unexpected death before age 50?		
13.	Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?		
14.	Has any family member been diagnosed with Hypertonic Cardiomyopathy?		
15.	Has any family member been diagnosed with Long QT Syndrome?		
16.	Has any family member been diagnosed with ion channelpathy (Brugada Syndrome,etc)?		
17.	Has any family member been diagnosed with Marfan's syndrome?		
18	Have you had a severe viral infections (myocarditis, mononucleosis, etc.) in the past year?		
19.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
20.	Have you ever had a head injury or concussion?		
21.	Have you ever been knocked out, become unconscious or lost your memory?		
22.	Have you ever experienced a seizure?		
23.	Have you ever had numbness in your arms, hands, legs or feet?		
24.	Have you ever had a stinger, burner or pinched nerve?		
25.	Are you missing any paired organs?		
26.	Are you presently under a doctor's care?		
27.	Are you currently taking any prescription or nonprescription medications or inhalers?		
28.	Do you have any allergies?		
29.	Have you ever been dizzy before or during exercise?		
30.	Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?		

31	Have you ever become ill after exercising or working in the heat?		
32.	Have you ever had any problems with your eyes or vision?		
33.	Have you ever gotten unexpectedly short of breath with exercise?		
34.	Do you have asthma?		
35.	Do you have seasonal allergies that require medical treatment?		
36.	Do you use any special protective or corrective equipment?		
37.	Have you ever had a sprain, strain or swelling after injury?		
38.	Have you ever broken or fractured any bones?		
39.	Have you ever dislocated any joints?		
40.	Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? If yes, please check the appropriate box and explain on separate sheet of paper.		
41.	Do you want to weigh more or less than you do now?		
42.	Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities?		
43.	Do you feel stressed out?		
44.	Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?		

Head		Shoulder		Wrist		Thigh		Foot	
Neck		Upper arm		Hand		Knee			
Back		Elbow		Finger		Shin/Calf			
Chest		Forearm		Hip		Ankle			

FEMALES ONLY

45.	When was your first menstrual period?	
46.	When was your most recent menstrual period?	
47.	How much time elapses from the start of one period to the start of another?	Days
48.	How many periods have you had in the last year?	
49.	What was the longest time between periods in the last year?	Days

If, in the judgment of any representative of the school, the above student should need immediate care and treatment result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school, and any school or hospital representative from any claim by any person on account of such care treatment of said student.

If, in between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the authorities of such illness or injury.

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT/GUARDIAN NAME: _____

PARENT SIGNATURE: _____DATE: _____

STUDENT SIGNATURE: _____ DATE: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____