HILL COUNTRY MONTESSORI SCHOOL – MEDICAL HISTORY FORM

Student's Name (Last, First, Middle) | Gender | Age | Date of Birth

Student's Address (Street, City, Zip) | Student's Home Phone Number

Parent/Guardian | Home Phone | Cell Phone | Work Phone

Parent/Guardian | Home Phone | Cell Phone | Work Phone

This medical history form must be completed annually by parent (or guardian) and student in order for the student to participate in 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.

Explain "yes" answers in the box below**. Circle questions to which you don't know the answers. Any "yes" answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in HCMS practices, games, or matches.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	❑	❑
2.	Have you been hospitalized overnight in the past year?	❑	❑
	Have you ever had surgery?	❑	❑
3.	Have you ever had prior testing for the heart ordered by a physician?	❑	❑
	Have you ever passed out during or after exercise?	❑	❑
	Have you ever had chest pain during or after exercise?	❑	❑
	Do you get tired more quickly than your friends do during exercise?	❑	❑
	Have you ever had racing of your hear or skipped heartbeats?	❑	❑
	Have you had high blood pressure or high cholesterol?	❑	❑
	Have you ever been told you have a heart murmur?	❑	❑
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	❑	❑
	Has any family member been diagnosed with enlarged heart (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Bruganda syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm?	❑	❑
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	❑	❑
	Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
4.	Have you ever had a head injury or a concussion?	❑	❑
	Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
	If yes, how many times?_____		
	When was the last concussion?_____		
	How severe was each one? (explain below)		
	Have you ever had a seizure?	❑	❑
	Do you have frequent or severe headaches?	❑	❑
	Have you ever had a stinger, burner, or pinched nerve?	❑	❑
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	❑	❑
5.	Are you missing any paired organs?	❑	❑
6.	Are you under a doctor's care?	❑	❑
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	❑	❑
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	❑	❑
9.	Have you ever been dizzy during or after exercise?	❑	❑
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
11.	Have you ever become ill from exercising in the heat?	❑	❑
12.	Have you had any problems with your eyes or vision?	❑	❑

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	❑	❑
	Do you have asthma?	❑	❑
	*If your child has asthma, an asthma action plan must be provided.		
	Do you have seasonal allergies that require medical treatment?	❑	❑
14.	Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?	❑	❑
15.	Have you ever had a sprain, strain, or swelling after injury?	❑	❑
	Have you broken or fractured any bones or dislocated any joints?	❑	❑
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	❑	❑
	If yes, check appropriate box and explain below.		
	❑ Head ❑ Upper Arm ❑ Hand ❑ Knee ❑ Neck ❑ Elbow ❑ Finger ❑ Shin/Calf ❑ Back ❑ Forearm ❑ Hip ❑ Ankle ❑ Chest ❑ Wrist ❑ Thigh ❑ Foot ❑ Shoulder		
16.	Do you want to weigh more or less than you do now?	❑	❑
	Do you lose weight regularly to meet weight requirements for your sport?	❑	❑
17.	Do you feel stressed out?	❑	❑
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		
	Females Only		
19.	When was your first menstrual period?		
	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?		
	How many periods have you had in the last year?		
	What was the longest time between periods in the last year?		

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, cardiologist, or nurse practitioner.

** EXPLAIN "YES" ANSWERS IN THE BOX BELOW (Attach additional sheet if necessary)

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Hill Country Montessori School, Inc. does not assume any responsibility in case an accident occurs. If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said 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 and treatment of said student. If, 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 school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by Hill Country Montessori School, Inc.

Student Signature:_____ Parent/Guardian Signature:_____ Date:_____

For School Use Only:

This Medical History Form was reviewed by: Printed Name:_____ Date:_____ Signature:_____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, OR CONTEST BEFORE, DURING, OR AFTER SCHOOL.

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Student's Name_____Sex_____Age_____Date of Birth_____

Height_____Weight_____%Body Fat (optional)_____Pulse_____BP___/____ (____/____), (____/____)
(Brachial blood pressure while sitting)

Vision R 20/_____ L 20/_____ Corrected: ❑ Y ❑ N Pupils: ❑ Equal ❑ Unequal

As a minimum requirement, this Physical Examination Form must be completed prior to Upper Elementary athletic participation and again prior to Middle School athletic participation in Hill Country Montessori School's extracurricular sports program.

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearances			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

❑ Cleared

❑ Cleared after completing evaluation/rehabilitation for:_____

❑ Not cleared for:_____Reason:_____

Recommendations:_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Name (print/type):_____

Signature:_____ Date:_____

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