Medical History Update Form

TO BE COMPLETED BY SECOND-YEAR OR RETURNING ATHLETES ONLY

Sport(s):		Year: **2010-11**
Name:		SID #:
Date of Birth:	Age:	E-Mail:
Local Address:		
Local Phone:		Cell Phone:

Emergency Contact:		Relationship:
Address:	City:	Zip Code:
Home Phone:	Cell Phone:	
Work Phone:	E-Mail:	

In the past year have you had any of the following:	Yes	No
Chest pain while exercising?		
Fainting or nearly fainting while exercising?		
Allergies?		
Unexplained shortness of breath or fatigue while exercising?		
Suffered from heat illness?		
Been knocked out or had a concussion? If yes, were you seen by a medical professional? Yes____ No____		
Any fractures, sprains or strains that caused you to miss a practice or game?		
Any chronic injuries (such as tendonitis, shin splints, back pain) that affected your ability to participate in athletics?		
Had any illness or condition that affected your ability to participate in athletics?		
Been treated by a physical therapist, athletic trainer, massage therapist or chiropractor?		
Are you taking any medication?		

Please explain any Yes answers:	
Signature:	Date: