Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Athlete First & Last Name:_____ **Preferred Name:**_____

Athlete Date of Birth (mm/dd/yyyy):_____ ☐ Female ☐ Male ☐ Other Gender Identity

STATE PROGRAM:_____ **E-mail:**_____

ASSOCIATED CONDITIONS - **Does the athlete have** *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:_____

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:_____
☐ Insect Bites or Stings:_____
☐ Food:_____

ASSISTIVE DEVICES - **Does the athlete use** *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device
☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures
☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid
☐ Implanted Device ☐ Inhaler ☐ Pacemaker
☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

Self-injurious behavior during the past year ☐ No ☐ Yes
Aggressive behavior during the past year ☐ No ☐ Yes
Depression *(diagnosed)* ☐ No ☐ Yes
Anxiety *(diagnosed)* ☐ No ☐ Yes

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes
Has any family member or relative died while exercising? ☐ No ☐ Yes
List all medical conditions that run in the athlete's family:

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last Name:_____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS								
Loss of Consciousness	No	Yes	High Blood Pressure	No	Yes	Stroke/TIA	No	Yes
Dizziness during or after exercise	No	Yes	High Cholesterol	No	Yes	Concussions	No	Yes
Headache during or after exercise	No	Yes	Vision Impairment	No	Yes	Asthma	No	Yes
Chest pain during or after exercise	No	Yes	Hearing Impairment	No	Yes	Diabetes	No	Yes
Shortness of breath during or after exercise	No	Yes	Enlarged Spleen	No	Yes	Hepatitis	No	Yes
Irregular, racing or skipped heart beats	No	Yes	Single Kidney	No	Yes	Urinary Discomfort	No	Yes
Congenital Heart Defect	No	Yes	Osteoporosis	No	Yes	Spina Bifida	No	Yes
Heart Attack	No	Yes	Osteopenia	No	Yes	Arthritis	No	Yes
Cardiomyopathy	No	Yes	Sickle Cell Disease	No	Yes	Heat Illness	No	Yes
Heart Valve Disease	No	Yes	Sickle Cell Trait	No	Yes	Broken Bones	No	Yes
Heart Murmur	No	Yes	Easy Bleeding	No	Yes	Dislocated Joints	No	Yes
Endocarditis	No	Yes	**If female athlete, list date of last menstrual period:**_____					

Describe any past broken bones or dislocated joints
(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability					
Difficulty controlling bowels or bladder	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Weakness in legs, arms, hands or feet	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Head Tilt	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Spasticity	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes
Paralysis	No	Yes	*If yes, is this new or worse in the past 3 years?*	No	Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW
(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form	Relationship to Athlete	Phone	Email

Athlete Medical Form – **PHYSICAL EXAM**

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:_____ **Date of Birth**_____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better — No Yes N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better — No Yes N/A

Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Right Ear Canal	Clear	Cerumen	Foreign Body	
Left Ear Canal	Clear	Cerumen	Foreign Body	
Right Tympanic Membrane	Clear	Perforation	Infection	NA
Left Tympanic Membrane	Clear	Perforation	Infection	NA
Oral Hygiene	Good	Fair	Poor	
Thyroid Enlargement	No	Yes		
Lymph Node Enlargement	No	Yes		
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater	
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater	
Heart Rhythm	Regular	Irregular		
Lungs	Clear	Not clear		
Right Leg Edema	No	1+ 2+	3+ 4+	
Left Leg Edema	No	1+ 2+	3+ 4+	
Radial Pulse Symmetry	Yes	R>L	L>R	
Cyanosis	No	Yes, describe		
Clubbing	No	Yes, describe		

Bowel Sounds	Yes	No			
Hepatomegaly	No	Yes			
Splenomegaly	No	Yes			
Abdominal Tenderness	No	RUQ	RLQ	LUQ	LLQ
Kidney Tenderness	No	Right	Left		
Right upper extremity reflex	Normal	Diminished	Hyperreflexia		
Left upper extremity reflex	Normal	Diminished	Hyperreflexia		
Right lower extremity reflex	Normal	Diminished	Hyperreflexia		
Left lower extremity reflex	Normal	Diminished	Hyperreflexia		
Abnormal Gait	No	Yes, describe below			
Spasticity	No	Yes, describe below			
Tremor	No	Yes, describe below			
Neck & Back Mobility	Full	Not full, describe below			
Upper Extremity Mobility	Full	Not full, describe below			
Lower Extremity Mobility	Full	Not full, describe below			
Upper Extremity Strength	Full	Not full, describe below			
Lower Extremity Strength	Full	Not full, describe below			
Loss of Sensitivity	No	Yes, describe below			

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.

OR

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (*TO BE COMPLETED BY EXAMINER ONLY*)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

This athlete is ABLE to participate in TopSoccer without restrictions. This athlete

is ABLE to participate in TopSoccer WITH restrictions. Describe → _____

This athlete MAY NOT participate in TopSoccer at this time & MUST be further evaluated by a physician for the following concerns:

Concerning Cardiac Exam	Acute Infection	O_2 Saturation Less than 90% on Room Air
Concerning Neurological Exam	Stage II Hypertension or Greater	Hepatomegaly or Splenomegaly
Other, please describe:		

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

Follow up with a cardiologist	Follow up with a neurologist	Follow up with a primary care physician
Follow up with a vision specialist	Follow up with a hearing specialist	Follow up with a dentist or dental hygienist
Follow up with a podiatrist	Follow up with a physical therapist	Follow up with a nutritionist

Other/Exam Notes:

	Name:
	E-mail:
Signature of Licensed Medical Examiner Exam Date	Phone: License #:

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name:_____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

In my professional opinion, this athlete MAY now participate in TopSoccer (indicate restrictions or limitations below):

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature	**Date**