HAMPSHIRE COLLEGE
HEALTH & COUNSELING SERVICES
893 West Street, Amherst, MA 01002
PH (413) 559.5458 FX (413) 559.5583
healthservices@hampshire.edu

SPORTS HEALTH FORM

THIS FORM IS REQUIRED FOR INTERCOLLEGIATE ATHLETES DUE JULY 1 FOR FALL AND JANUARY 15 FOR SPRING

Name:_____ Sex_____ Age_____ DOB_____

Home Address:_____ Phone_____

Sport(s)_____

In case of emergency, contact:_____ **Personal Physician**_____

Relationship_____**Phone (H)** _____ **Phone (W)**_____

Explain "Yes" Answers below. Circle questions you don't know the answers to.

	YES	NO
Has a doctor ever denied or restricted your participation in sports for any reason?	◯	◯
Do you have an ongoing medical condition (like diabetes or asthma?	◯	◯
Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?	◯	◯
Do you have allergies to medicines, pollens, foods, or stinging insects?	◯	◯
Have you ever passed out or nearly passed out DURING exercise?	◯	◯
Have you ever passed our or nearly passed out AFTER exercise?	◯	◯
Does your heart race or skip beats during exercise?	◯	◯
Has a doctor ever told you that you have (check all that apply): High blood pressure High Cholesterol A heart murmur A heart infection	◯	◯
Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	◯	◯
Has anyone in your family died for no apparent reason?	◯	◯
Does anyone in your family have a heart problem?	◯	◯
Has any family member or relative died of heart problems or of sudden death before age 50?	◯	◯
Does anyone in your family have Marfan syndrome?	◯	◯
Have you ever spent the night in a hospital?	◯	◯
Have you ever had surgery?	◯	◯
Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that cause you to miss a practice or a game? If yes, circle affected area below	◯	◯
Have you had any broken or fractured bones or dislocated joints? If yes, circle below	◯	◯
Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below	◯	◯

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes

Have you ever had a stress fracture?	◯	◯
Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	◯	◯
Do you regularly use a brace or assistive device?	◯	◯

	YES	NO
Has a doctor ever told you that you have asthma or allergies?	◯	◯
Do you cough, wheeze, or have difficulty breathing during or after exercise?	◯	◯
Is there anyone in your family who has asthma?	◯	◯
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	◯	◯
Have you had infectious mononucleosis (mono) within the last month?	◯	◯
Do you have any rashes, pressure sores, or other skin problems?	◯	◯
Have you had a herpes skin infection?	◯	◯
Have you ever had a head injury or concussion?	◯	◯
Have you been hit in the head and been confused or lost your memory?	◯	◯
Have you ever had a seizure?	◯	◯
Do you have headaches with exercise?	◯	◯
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	◯	◯
Have you ever been unable to move your arms or legs after being hit or falling?	◯	◯
When exercising in the heat, do you have severe muscle cramps or become ill?	◯	◯
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	◯	◯
Have you had any problems with your eyes or vision?	◯	◯
Do you wear glasses or contact lenses?	◯	◯
Do you wear protective eyewear, such as goggles or a face shield?	◯	◯
Are you happy with your weight?	◯	◯
Are you trying to gain or lose weight?	◯	◯
Has anyone recommended you change your weight or eating habits?	◯	◯
Do you limimt or carefully control wha tyou eat?	◯	◯
Do you have any concerns that you would like to discuss with a doctor?	◯	◯
FEMALES ONLY		
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

Explain "Yes" answers here: _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date_____

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Name: _____ Sex_____ Age_____ DOB_____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse BP_____/_____ (_____/_____ , _____/_____)

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

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

○ Education done: Drugs/ETOH_____ Safe Sex/STD_____ TSE _____ BSE _____ Eating Concerns_____

○ Cleared without restriction

○ Cleared, with recommendations for further evaluation or treatment for: _____

_____

_____

Not cleared for: ○ All Sports ○ Certain Sports:_____

Reason: _____

_____

Recommendations: _____

_____

_____

Signature of MD, DO, NP, or PA_____ Date:_____