Participant Emergency Information Form

Name: ______________________________ Activity/Trip: ______________________
SS#: ______ - _____ - ___________ Dates of Trip: ______________________

Sex: **M or F** Age: ______ Date of birth: ______/______/__________
Height:______' _____" Weight: ____ lbs. Eye color: _________ Hair color: ________

In Case of Emergency, Please Contact:

Name: ______________________________ Relationship to Participant: ___________
Phone: ______________________________ Alternate Phone: ____________________

Alternate Contact: ____________________ Phone: ____________________________

Doctor's Name: ______________________ Doctor's Phone: _____________________
Medical Policy/Group: _______________ Medical Phone: _____________________

Participant Health Form

We require full disclosure of your current health. The information you provide may assist people in the unlikely event of an accident. Therefore, before you fill this form out, please read it carefully. Complete and accurate completion of all sections is very important.

Explain "Yes" answers on the next page. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?		
2.	Do you have an ongoing or chronic illness?		
3.	Have you ever been hospitalized overnight?		
4.	Have you ever had surgery?		
5.	Are you currently taking prescription or non-prescription (over-the-counter) pills or medications or using an inhaler?		
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
7.	Do you have any phobias or fears?		
8.	Can you swim?	☐	☐
9.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
10.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
11.	Have you ever passed out during or after exercise?	☐	☐
12.	Have you ever been dizzy during or after exercise?	☐	☐
13.	Have you ever had chest pain during or after exercise?	☐	☐
14.	Do you get tired more quickly than your friends do during exercise?	☐	☐
15.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
16.	Have you had high blood pressure or high cholesterol?	☐	☐
17.	Have you ever been told you have a heart murmur?	☐	☐

		Yes	No
18.	Has any family member or relative died of heart problems or of sudden death before the age 50?	☐	☐
19.	Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?	☐	☐
20.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
21.	Do you have any current skin problems (i.e.: itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
22.	Have you ever had a head injury or concussion?	☐	☐
23.	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
24.	Have you ever had a seizure?	☐	☐
25.	Do you have frequent or severe headaches?	☐	☐
26.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
27.	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
28.	Have you ever become ill from exercising in the heat?	☐	☐
29.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
30.	Do you have asthma?	☐	☐
31.	Do you have seasonal allergies that require medical treatment?	☐	☐
32.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐

	Yes	No
33. Have you had any problems with your eyes or vision?		
34. Do you wear glasses, contacts, or protective eyewear?		
35. Have you ever had a sprain, strain, or swelling after an injury?		
36. Have you broken or fractured any bones or dislocated any joints?		
37. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate box and explain to the right

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

	Yes	No
38. Do you want to weigh more or less than you do now?		
39. Do you lose weight regularly to meet weight requirements for your sport?		
40. Do you feel stressed out?		
41. Do you smoke? (please identify option you will use)		
42. Are you currently taking any medication?		

Please list dietary restrictions (including vegetarian, etc)

____

FEMALES ONLY

43. When was your last menstrual period? ____________
45. How much time do you usually have from the start of one period to the start of another? ________ days
46. How many periods have you had in the last year? ____
47. What was the longest time between periods in the last year? ______________________

Explain "yes" answers here:

____

____

____

____

____

Please list current medications and dosages:

____

____

____

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

Participant Signature: ____________________________ Date: ________________________________

Parent/Guardian Signature: ________________________ Date: ________________________________

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ______________________________________

____

☐ Not cleared for: _______________ Reason: ____________________________________

Recommendations: ____

____

____

Name of physician (print): ______________________________ Date: ____________________

Address: ____ Phone: ____________________

Signature of physician: ____________________________________, MD or DO.

Adapted from © *1997* American Academy of family Physicians, American Academy of Pediatrics, American Medical Society of Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.