

Steens Mountain

HIGH ALTITUDE RUNNING CAMP

Pre-Participation Medical History Form

Name: _____ Date of Birth: ___/___/___ Age: _____ Female Male

Grade: ___ School: _____ Coach: _____

Personal Physician: _____ Phone: () _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: (h) _____ (w) _____

Explain "Yes" answers below. Please circle questions you don't know the answer to.

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have any chronic medical conditions (i.e. asthma, diabetes, seizures, etc.)?
3. Are you currently taking any prescription or 'over-the-counter' medicine?
4. Do you have any allergies to medicines, foods, pollens, or insect (bee) stings?
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?
6. Have you ever had pain, pressure, or discomfort in your chest during exercise?
7. Does your heart race or skip beats during exercise?
8. Has your doctor ever told you that you have a heart murmur?
9. Has your doctor ever ordered a test for your heart (i.e. EKG or echocardiogram)?
10. Has anyone in your family ever died for no apparent reason before the age of 50?
11. Does anyone in your family have Marfan Syndrome?
12. Have you ever spent the night in a hospital?
13. Have you ever had surgery?
14. Has a doctor ever told you that you have asthma or allergies?
15. Do you cough, wheeze, or have difficulty breathing during or after exercise?
16. Were you born without or are you missing a kidney, eye, testicle, or other organ?
17. Have you had infectious mononucleosis (Mono) within the last month?
18. Do you have any rashes or other skin problems?
19. Have you ever had a herpes skin infection?
20. Have you ever had a head injury or concussion?
21. Have you ever had a seizure?
22. Do you have headaches with exercise?
23. When exercising in the heat, do you have severe muscle cramps or become ill?
24. Does anyone in your family have Sickle Cell Disease or Sickle Cell Trait?
25. Do you have problems with your eyes or vision?
26. Do you wear glasses or contact lenses?
27. Are you trying to gain or lose weight?
28. Do you limit or carefully control what you eat?
29. Are your immunizations up to date? If "No", please explain below.
30. Have you ever had an injury that caused you to miss a practice, game, or meet?
31. Have you ever had a fractured or dislocated bone?
32. Have you ever had a bone or joint that required imaging (i.e. X-ray, CT, MRI)?
33. Have you ever had a stress fracture?
34. Have you ever been told you need an x-ray for alantoaxial (neck) instability?
35. Do you regularly use a brace or assist device?

	Yes	No
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	<input type="checkbox"/>
9	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>
13	<input type="checkbox"/>	<input type="checkbox"/>
14	<input type="checkbox"/>	<input type="checkbox"/>
15	<input type="checkbox"/>	<input type="checkbox"/>
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30	<input type="checkbox"/>	<input type="checkbox"/>
31	<input type="checkbox"/>	<input type="checkbox"/>
32	<input type="checkbox"/>	<input type="checkbox"/>
33	<input type="checkbox"/>	<input type="checkbox"/>
34	<input type="checkbox"/>	<input type="checkbox"/>
35	<input type="checkbox"/>	<input type="checkbox"/>

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 _____ Signature of Parent/Guardian _____ Date _____