



DCSD Athletic/Activity Medical Information

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M F

Year in School: 9th 10th 11th 12th Sport (s): \_\_\_\_\_

Allergies: (include medication, food, latex or other allergies):

\_\_\_\_\_

Medications (List ALL you are currently taking, including birth control pills):

\_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

List any body piercing you have other than on your ears: \_\_\_\_\_

List any surgeries you have had and the approximate date(s): \_\_\_\_\_

\*\*Please answer the following questions carefully and as accurately as possible. If you answer yes to any question, please provide the date of occurrence and the care that was received\*\*

Concussion History: It is extremely important that this be honest and accurate.

How many and when? \_\_\_\_\_

Did you lose consciousness? Yes No Did you require care by a doctor? Yes No

Have you ever been told by a doctor that you could not participate in a practice or game following a concussion? Yes No

Have you ever been advised by a doctor to wear protective head gear during sports? \_\_\_\_\_

Do you wear any type of protective head gear during sports? \_\_\_\_\_

Table with 2 columns: Question, YES, NO. Rows include questions about dizziness, chest pain, fatigue, heart problems, skin issues, heat/cramps, stingers, and special equipment.

Please answer the following:

Have you ever had an injury or a fracture to any of the following:

Table with 3 columns: Injury Type, YES, NO, and When/Treatment. Lists injuries from Head/neck to Foot.

