



## Dairyland Sports Medical Information Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

Name of Legal Guardian if Athlete is a Minor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Primary Qualifying Medical Diagnosis \_\_\_\_\_

To move in your environment every day, do you walk, use a manual wheelchair, power wheelchair, or an assistive device?

### **Past Medical History/ Past Surgical History**

**Please list any medical issues or surgeries related to the following organ systems:**

**Head/Eyes** [If VP shunt present, please include approximate date of last infection or revision.; include history of prior concussions/ TBI, use of glasses/contacts]

**Ears, Nose Throat** [Please include use of hearing aids, if applicable]

**Lungs/Chest**

**Heart** [Please include history of dizziness and/or passing out with date of most recent episode]

**Abdomen**

**Bowel and Bladder** [Please describe bowel and bladder protocol if relevant]

**Spine and Joints** [Please describe presence of motor weakness, joint contractures and scoliosis; include hx of significant joint injuries and fractures; include brief summary of orthopedic/spinal fusion surgical procedures if applicable]

**Please list any medical issues or surgeries related to the following organ systems (continued)**

**Nervous System** [If history of seizures present, please describe what seizures look like and approximate date of last seizure; describe presence and location of spasticity, include history of tethered cord and symptoms if applicable]

**Skin** [Please include pressure ulcer history and locations of current ulcers]

**Immunology** [Please include most recent hospitalization and most recent significant or recurrent infection]

**Equipment and Bracing** [Please describe wheelchairs/assistive devices or other equipment used for sports, current braces and splints]

**Training History** [Please include how many hours per week you train, if you work with a coach, and sports you will be competing in]

**Describe medical issues made worse with exercise and date of last exacerbation.**

**Family History:**

Any family history of sudden cardiac death or heart attack before age 50 years old? Yes / No

**Current Medications**

**Allergies** including specific reaction from particular food or medication

**Immunizations**

Approximate date of last tetanus shot \_\_\_\_\_

Are immunizations up to date? Yes / No

Permission is given to Dairyland Games Staff and/or the local competition organizing committee to seek medical care in case of emergency for the above named person.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/ Guardian if person is under age 18 \_\_\_\_\_ Date \_\_\_\_\_