

## The Baptist College of Florida Medical History Evaluation Form

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **Student #:** \_\_\_\_\_  
**Year in College:** Fr. Soph. Jr. Sr. **Sport:** \_\_\_\_\_  
**Local Address:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Parent/Guardian's Name:** \_\_\_\_\_ / \_\_\_\_\_  
**Parent/Guardian's Address:** \_\_\_\_\_  
**Parent/Guardian's Phone # (\_\_\_\_\_)** \_\_\_\_\_  
**Emergency Contact Person's Name** \_\_\_\_\_  
**Emergency Contact Person's Number (\_\_\_\_\_)** \_\_\_\_\_  
**Emergency Contact Person's Relationship to Student:** \_\_\_\_\_  
**I have medical insurance – YES** \_\_\_\_ **NO** \_\_\_\_  
**If Yes, please provide the name of the insurance company** \_\_\_\_\_,  
**Group #** \_\_\_\_\_, **and Insurance ID #** \_\_\_\_\_

- YES NO** 1. Are you allergic to any substances and/or medications? List: \_\_\_\_\_  
 \_\_\_\_\_  
**YES NO** 2. Do you take any medications on a regular basis? List \_\_\_\_\_  
**YES NO** 3. Do you have epilepsy, or ever suffered a seizure? Date of last seizure: \_\_\_\_\_  
**YES NO** 4. Have you been treated for diabetes? Medication: \_\_\_\_\_  
**YES NO** 5. Has a physician ever told you that you are anemic?  
**YES NO** 6. Have you been diagnosed with Sickle Cell Disease?  
**YES NO** 7. Have you ever been diagnosed with the following? (Circle all that apply)  
 High Blood Pressure Heart Murmur Heart Infection Any Other Heart Condition  
**YES NO** 8. Have you ever passed out or nearly passed out DURING exercise?  
**YES NO** 9. Have you ever passed out or nearly passed out AFTER exercise?  
**YES NO** 10. Have you ever had discomfort, pain, or pressure in your chest during exercise?  
**YES NO** 11. Have you ever had any of the following diseases? (Circle all that apply)  
 Heart Kidney Lung Liver  
**YES NO** 12. Do you have asthma? Medication: \_\_\_\_\_  
**YES NO** 13. Have you ever had a hernia? Has it been repaired? \_\_\_\_\_  
**YES NO** 14. Have you ever been knocked unconscious? Date: \_\_\_\_\_  
**YES NO** 15. Have you ever had a head injury or concussion? Date: \_\_\_\_\_  
**YES NO** 16. Have you ever had a head injury involving bones, nerves, or discs (stingers?  
 fractures, loss of feeling, numbness, or pain)? Date and type: \_\_\_\_\_  
 \_\_\_\_\_  
**YES NO** 17. Have you ever had a shoulder injury? Date and type: \_\_\_\_\_  
**YES NO** 18. Have you ever had shoulder surgery? Date and type: \_\_\_\_\_  
**YES NO** 19. Have you ever had a back injury? Date and type: \_\_\_\_\_

- YES NO** 20. Have you ever had back surgery? Date and type: \_\_\_\_\_  
**YES NO** 21. Have you ever had a hip/pelvis injury? Date and type: \_\_\_\_\_  
**YES NO** 22. Have you ever had hip/pelvis surgery? Date and type: \_\_\_\_\_  
**YES NO** 23. Have you ever had a knee injury? Date and type: \_\_\_\_\_  
**YES NO** 24. Have you ever had knee surgery? Date and type: \_\_\_\_\_  
**YES NO** 25. Have you ever had a lower leg injury? Date and type: \_\_\_\_\_  
**YES NO** 26. Have you ever had an ankle injury? Date and type: \_\_\_\_\_  
**YES NO** 27. Have you ever had ankle surgery? Date and type: \_\_\_\_\_  
**YES NO** 28. Have you ever had an injury to your elbow, wrist, hand, or foot?  
Date and type: \_\_\_\_\_  
**YES NO** 29. Do you have a metal implant in your body (pin, plate, screw, etc.)?  
Where: \_\_\_\_\_  
**YES NO** 30. Are you happy with your weight?  
**YES NO** 31. Are you trying to lose or gain weight? (Indicate which one)  
**YES NO** 32. Has anyone recommended you change your weight or eating habits?  
**YES NO** 33. Do you limit or carefully control what you eat?  
**YES NO** 34. At any time during the school year do you practice the act of fasting for  
personal or religious reasons?  
**YES NO** 35. Have you ever been diagnosed with Marfan's Syndrome?  
**YES NO** 36. Have you ever been diagnosed with a bleeding disorder? Which one: \_\_\_\_\_  
**YES NO** Do you have any other medical conditions/concerns not already addressed on this  
form? List and explain: \_\_\_\_\_  
\_\_\_\_\_

I hereby certify the answers to these questions are correct and true. I understand that The Baptist College of Florida cannot be held responsible for any previous medical conditions. I understand that this medical history form is for no other purpose than to clear me for athletic participation at The Baptist College of Florida. I understand that based upon the answers above, I may be required to secure a physician's release prior to participation in athletics at The Baptist College of Florida.

**Student Signature:** \_\_\_\_\_

**Parent/Guardian Signature (if student is under 18):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**For Office Use Only**

Student is:    \_\_\_ Cleared to participate    \_\_\_ Not cleared to participate

Assistant to the Director of Operations/Comptroller's  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_