



Form 11
2017 Adaptive Sports USA Junior Nationals™
Athlete Medical



(To be completed by the athlete/parent)

Name (last, first) _____ DOB: _____ Age: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Emergency Phone # _____

INSURANCE INFORMATION:

Insurance Company _____ Policy Number _____

Dental Insurance Company _____ Policy Number _____

DIAGNOSIS: _____ **SEX:** Male Female

In case of emergency whom should we notify? _____

ALLERGIES (be specific):

Medications _____

Environmental/food/other _____ Latex: Yes No

What are your symptoms from an allergic reaction?

CURRENT MEDICATIONS: _____

PAST SURGERIES: _____

Do you have a shunt in place? Yes No

Have you ever had a shunt malfunction? Yes No

If yes, what were the symptoms? _____

Have you ever had a tethered spinal cord? Yes No

If yes, what were the symptoms? _____

Have you ever been knocked out or had a concussion? Yes No

If yes, describe the incident. _____

Do you have any history of seizures? Yes No

Do you have a history of heart disease, heart murmurs, or high blood pressure? Yes No

Has anybody in your family had a sudden death or heart attack before 50 years? Yes No

Have you ever been dizzy or passed out with exercise? Yes No

Adaptive Sports USA Junior Nationals Athlete Medical Form

Name (last, first) _____

Have you ever had any fractures, sprains, or strains (F=fracture, S=strain or sprain)?

Neck _____ Arm _____ Hip _____ Elbow _____
Back _____ Hand _____ Thigh _____ Knee _____
Shoulders _____ Fingers _____

Do you have scoliosis? Yes No

Have you had a back fusion? Yes No

Do you have any organs missing? Yes No

Specify: _____

Do you wear glasses contact lenses hearing aides dental appliances (check all that apply)

What type of bladder management do you use? (check all that apply)

None Indwelling catheter Intermittent catheter

Other (specify) _____

Have you had any recent (last 3 months) bladder infections? Yes No

Do you have any problems with constipation or loose stools? Yes No

Do you have any history of pressure ulcers requiring surgery? Yes No

Do you have any current pressure sores? Yes No

Where are they and how are you treating them?

1) _____

2) _____

If applicable, what type of wheelchair cushion do you use? _____

Do you have any chronic illnesses? Yes No (If Yes, specify) _____

Date of last tetanus shot _____

Are your other immunizations up-to-date? Yes No (If NO, why) _____

Do you wear braces? Yes No What type? _____

How many hours per week do you train? _____

Do you have a coach? Yes No Who? _____

What sports do you participate in? _____

Do you have any problems with: (check all that apply):

Overheating _____ Dysreflexia _____ Spasticity _____ Pain _____

Are any of the problems made worse by exercise? Yes No (specify) _____

Are any of the problems made better by exercise? Yes No (specify) _____

Permission is given to Adaptive Sports USA and/or the local 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 _____