Hamilton High School
Sports Medicine
Information Sheet

Date ______ / ______ / ______
(Month Day Year)

Name ________________________________ Sport ________________________
Last, First

Date of Birth ______ / ______ / ______ Grade Level 9th 10th 11th 12th
Month Day Year

Insurance Information

Company Name ____

Policy # ________________________________

Health History

Allergies (Medication, Food , Others) ____

Asthma Yes No ________________________________
(Medication or Inhaler Used)

Sickle Cell Trait Yes No

Diabetes Yes No

Epilepsy Yes No

Heat Illness Yes No ________________________________
(Explain) (Date of last episode)

Concussion Yes No ____________________
(Date of last Concussion)

Medication currently being taken ____

List Serious Illness/ Injury/ Surgery (Month/ Year) ________________________________

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________________________________ ____________________
Parent Signature *Date*

Revised 2/4/2010

Hamilton High School
Sports Medicine
Cardiovascular Screening

Name ______________________________ Date of Birth ____/____/____
Last, First (Month Day Year)

1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?		
2) Has your child ever had extreme shortness of breath during exercise?		
3) Has your child had extreme fatigue associated with exercise (different from other children)?		
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?		
5) Has a doctor ever ordered a test for your child's heart?		
6) Has you child ever been diagnosed with an unexplained seizure disorder? ... or been diagnosed with exercised-induced asthma not well controlled with medication?		
7) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accident, drowning, or near drowning)		
8) Are there any family members who died suddenly of "heart problems" before age 50?		
9) Are there any family members who have unexplained fainting or seizures?		
Enlarged Heart:		
10) Hypertrophic Cardiomyopathy (HCM)		
11) Dilated Cardiomyopathy (DCM)		
Heart Rhythm problems:		
12) Long QT syndrome (LQTS)		
13) Short QT syndrome		
14) Brugada syndrome		
15) Catecholaminergic polymorphic ventricular tachycardia (CPVT)		
16) Arrhythmogenic right ventricular cardiomyopathy (ARVC)		
17) Marfan syndrome (aortic rupture)		
18) Heart attack, age 50 or younger		
19) Pacemaker or implanted defibrillator		
20) Deaf at birth (congenital deafness)		

Please explain more about any "yes" answers here: ______________________________

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______________________________ ______________________________

Parent Signature *Date*

Revised 5/25/2010

HAMILTON HIGH SCHOOL
Injury Evaluation
Permission Form

At Hamilton High School, the health and well being of your son or daughter is the highest priority of the Sports Medicine Team. Injury is always possible while participating in athletics. The Hamilton Sports Medicine Team requests permission to evaluate and or treat your son or daughter if the need arises.

Please sign and date the permission form below.

Hamilton Sports Medicine Team

1) Lance A. Michel, MEd., ATC
   Head Certified Athletic Trainer
   Hamilton High School
   www.michel.lance@cusd80.com
2) Alicia Langford, MEd., ATC
   Assistant Certified Athletic Trainer
   Hamilton High School
   www.Langford.alicia@cusd80.com

   Jessica Caselden, ATC
   Assistant Certified Athletic Trainer
   Hamilton High School
3) Matthew D. Overlin, MPAS, PA-C, ATC
   Sports Medicine Physician Assistant
   FASTMED
   www.FastMed.com
   (480) 277-6787
4) P. Dean Cummings, M.D.
   Orthopedic Surgeon, Sports Medicine
   THE ORTHOPEDIC CLINIC
   TOCA
   www.tocamd.com
   (602) 277-6211

Permission Form

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(Print Please) Name of Student/Athlete

I, ______________________________ give members of the Sports Medicine
(Print parent/guardian name)
Team permission to evaluate and or treat my son or daughter.

______________________________ Date ______________
(Parent/Guardian Signature)