



**ANSWER ALL QUESTIONS (All "YES" Answers Require an Explanation on a Separate Page EXCEPT # 8, 9, and 27)**

1	Have you ever been advised by a physician or by your parents not to participate in athletic events?	YES	NO	1
2	Have you been treated for a disease or illness during the past 12 months?	YES	NO	2
3	Has your physical activity been restricted for any reason during the past five years?	YES	NO	3
4	Are you currently under the care of a physician?	YES	NO	4
5	Are you currently taking medications (pills, sprays, or any other kind of treatment)?	YES	NO	5
*6	Have you had any surgical operations?	YES	NO	6*
7	Have you been admitted to the hospital for disease, illness, or injury?	YES	NO	7
8	Do you wear glasses?	YES	NO	8
9	Do you wear contact lenses?	YES	NO	9
10	Have you had any difficulty with your eyes (e.g. double vision, burning, blurry vision)?	YES	NO	10
11	Do you have difficulty hearing, frequent ear aches or drainage from your ears (other than wax)?	YES	NO	11
12	Have you had any contagious skin conditions (e.g. athlete's foot, warts, boils, herpes)?	YES	NO	12
13	Do you have a stuffy nose when you do not have a cold?	YES	NO	13
14	Have you ever had a head injury with unconsciousness?	YES	NO	14
15	Do you have any difficulty with chest tightness, cough, wheezing, or prolonged shortness of breath?	YES	NO	15
16	Have you had any trouble with your stomach or intestines (e.g. nausea, vomiting, gas, diarrhea, bloody stools)?	YES	NO	16
17	Have you had blood in your urine?	YES	NO	17
18	Have you ever had any weakness or trouble moving part of your body (such as a "stinger")?	YES	NO	18
19	Have you ever had a heat illness (such as heat exhaustion or heat stroke)?	YES	NO	19
20	Have you ever had an injury that caused you to miss a week of practices or a game?	YES	NO	20
21	Have you ever experienced a loss of consciousness during exercise?	YES	NO	21
22	Have you ever had:			
	a. Head Injury	YES	NO	22a
	b. Neck Injury or Pain, or Pinched Nerve	YES	NO	22b
	c. Lower Back Injury or Pain	YES	NO	22c
	d. Shoulder Injury or Pain	YES	NO	22d
	e. Elbow Injury or Pain	YES	NO	22e
	f. Wrist / Hand Injury or Pain	YES	NO	22f
	g. Hip Injury or Pain	YES	NO	22g
	h. Pulled Hamstring	YES	NO	22h
	i. Bruised Thigh	YES	NO	22i
	j. Knee Injury or Pain	YES	NO	22j
	k. Lower Leg Injury or Pain	YES	NO	22k
	l. Ankle / Foot Injury	YES	NO	22l
23	Are you allergic to any drugs, medications, foods, or stinging insects?	YES	NO	23
24	Have you ever had manipulations or treatments for your back or joints by anyone other than a physician?	YES	NO	24
25	Have you been found to have only one organ of usually paired organs (e.g. one kidney, one eye, one testicle, etc.)?	YES	NO	25
26	Do you have a permanent bridge, crown, or jacket, removable partial, or full plate?	YES	NO	26
27	Do you consider yourself to be in good physical health?	YES	NO	27
28	Do you have any questions regarding your health that you would like to discuss with a physician?	YES	NO	28
29	<b>FEMALE ATHLETES ONLY:</b>			
	a. Do you have any menstrual irregularity?	YES	NO	29a
	b. Do you take birth control pills?	YES	NO	29b
	c. Do you have a contraceptive device?	YES	NO	29c
	d. When was your last normal period? _____			

ALL OF THE QUESTIONS ABOVE HAVE BEEN ANSWERED TO THE BEST OF KNOWLEDGE.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Date

I hereby grant permission to SIU team physicians and/or their consulting physicians to render my son or daughter or myself any treatment or medical or surgical care that they deem reasonably necessary to the health and well-being of the athlete. I also hereby authorize the athletic trainers at SIU, who are under the direction and guidance of the SIU team physicians, to render to my son or daughter or myself any preventive first aid, rehabilitative or emergency treatment that they deem reasonable and necessary to the well-being of the athlete. This includes practices, games and travel. Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

\_\_\_\_\_  
(Parent / Guardian Signature (If Under Age 18))

\_\_\_\_\_  
Date

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Date

\* Please attach a copy of the surgical report for any operation you have had. This can be obtained from the attending physician.

I hereby grant permission to the SIUC Team Physicians and or their consulting physicians to render to my son or daughter or myself any treatment or medical or surgical care that they deem reasonably necessary to the health and well-being of the athlete. I also hereby authorize the athletic trainers at SIUC who are under the direction and guidance of the SIUC team physicians to render to my son or daughter or myself any preventative first aid, rehabilitative or emergency treatment that they deem reasonable and necessary to the health and well-being of the athlete. This includes practices, games, and travel. Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

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Student Signature

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Date

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Sport

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Parent / Guardian Signature (if under 18)

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Date

Please return to: Athletic Training Staff  
Department of Intercollegiate Athletics  
Southern Illinois University at Carbondale  
Carbondale IL. 62901-6620

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

SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE

SS# \_\_\_\_\_

Sport: \_\_\_\_\_

DEPARTMENT OF INTERCOLLEGIATE ATHLETICS

Date of Birth \_\_\_\_\_

Year In School 1 2 3 4 5

INTERIM HEALTH QUESTIONNAIRE

Age: \_\_\_\_\_

I AM ALLERGIC TO THE FOLLOWING MEDICATIONS:	CURRENT MEDICATIONS:

Name \_\_\_\_\_  
 Local / Campus Address \_\_\_\_\_ Phone \_\_\_\_\_

IN CASE OF EMERGENCY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_

CIRCLE ONE

1	Since the end of spring semester have you had an illness or injury that restricted your physical activity or has prevented you from practicing or competing or have you been hospitalized?	YES	NO
2	Are you currently under the care of a physician or taking any kind of medicine on a daily basis? (Please list current medications in the upper right-hand corner.)	YES	NO
3	Do you, your parents, or physician at home believe that there should be any limitation to your full participation in sports?	YES	NO
4	Have you had any change in your vision in the past year?	YES	NO
5	Have you sustained a head injury since last spring semester?	YES	NO
6	SIUC does not require a full physical exam for returning student-athletes. This interim health form is used to identify specific problems that have developed since your last physical exam. Do you wish to have a physical examination?	YES	NO
7	Women Athletes: Have you developed menstrual irregularity or difficulty in the past year?	YES	NO
8	Women Athletes: When was the first day of your last menstrual period?		

Please explain all "YES" answers: \_\_\_\_\_

Have you, at any time, requested a refund of your student health insurance for the current semester? YES NO

By signing below, I attest that all questions have been answered completely and truthfully to the best of my knowledge

\_\_\_\_\_  
Student-Athlete's Signature

\_\_\_\_\_  
Date

**Athletic Trainer Review:      Physical Required?      YES      NO**

\_\_\_\_\_  
Athletic Trainer's Signature

\_\_\_\_\_  
Date

Date: \_\_\_\_\_  
 Sport: \_\_\_\_\_  
 Year In School 1 2 3 4 5

SS# \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Age: \_\_\_\_\_

**Southern Illinois University  
 Department of Intercollegiate Athletics  
 Cardiovascular History Form**

\_\_\_\_\_  
 LAST NAME (PRINT) FIRST NAME MIDDLE INITIAL

\_\_\_\_\_  
 LOCAL ADDRESS

\_\_\_\_\_  
 LOCAL PHONE

Have any of your parents, grandparents, brothers or sisters had any of the following?	YES	NO	DON'T KNOW	RELATIONSHIP
High Blood Pressure				
Heart attack before age 50				
Sudden death of unknown cause before age 50				
Sudden death or loss of consciousness during exercise				
Disability or death from heart disease				
Disability or heart disease before age 50				
Stroke before age 50				
Prolonged Q-T Syndrome				
Marfan's Syndrome				

Have you ever had:	YES	NO	DON'T KNOW	REMARKS
High blood pressure				
If "Yes," list any medications you are taking to control your high blood pressure here:				
Rheumatic fever				
Loss of consciousness, or near loss of consciousness during exercise				
Severe chest pains during exercise				
Excessive, or more than expected, shortness of breath during exercise				
Excessive, or more than expected, fatigue during exercise				
Heart murmur				
Pneumothorax (collapsed lung)				
Has your physical activity ever been restricted because of any of the above?				

ALL OF THE QUESTIONS ABOVE HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
 Athlete's Signature

\_\_\_\_\_  
 Date