

Name \_\_\_\_\_  
**HA. HEALTH RECORD UPDATE-ATHLETICS**



**Athletic Department**  
 Health Record

1025 North Broadway  
 Milwaukee, WI 53202  
 414-277-2812  
 Fax: 414-277-2495  
 In Person: K156A  
[www.msoe.edu/health](http://www.msoe.edu/health)

Year in School:  FR  SOPH  JR  SR

Athlete **Sport** \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Middle

Date of Birth     /    /     Gender:  MALE  FEMALE Expected Graduation Year \_\_\_\_\_  
MM DD YY

Residence Hall \_\_\_\_\_ Cell or Campus Phone \_\_\_\_\_  
Residence Hall Room Number

Off Campus Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
(for commuter students) Street City State Zip

Permanent Home Address: \_\_\_\_\_ Business Phone \_\_\_\_\_  
(if different from above) Street City State Zip

Emergency Contact \_\_\_\_\_ Home Phone \_\_\_\_\_  
Name Relationship

Medical Insurance \_\_\_\_\_  
Company Policy Number Group Number Phone # (Member Services)

**TETANUS-DIPHTHERIA-PERTUSSIS** (Must have booster with Td or Tdap in the last ten years)     /    /      
MM DD YY

**HEALTH HISTORY REPEATED FOR MSOE ATHLETIC TRAINER**

	Circle One	Comments	Immune suppressed?	Yes No
Dx Arthritis/Limitations	Yes No		Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)	Yes No
Diagnosis of Asthma? Wheeze/Cough During or After Play?	Yes No	Indicate Severity:	Hospitalizations? When? What for?	Yes No
Back Problems?	Yes No		Surgery? (List All) When? What for?	Yes No
Birth Defects?	Yes No			
Developmental Delay?	Yes No		Serious Injury or Illness?	Yes No
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	Yes No		Tobacco Use (Type, Frequency)?	Yes No
Diabetes?	Yes No		Alcohol/Drug Use?	Yes No
Head Injury/Concussion/Passed Out?	Yes No			
Seizures? What are they like?	Yes No		Family History of Sudden Death Before Age 50? (Cause?)	Yes No
Rapid, Irregular Pulse/Shortness of Breath?	Yes No		<b>Current Medications</b>	
Heart Murmur/High Blood Pressure/Passing out?	Yes No		(Circle) Bridge Plate Dental Braces Other Molars-remain/removed	
Dizziness or Chest Pain with Exercise?	Yes No		(Circle) Eye/Vision Problems? Glasses Contacts Last Exam Date _____ Other Concerns?	
Bone/Joint Problems/Injury? Scoliosis?	Yes No		Are you presently under care for a medical or emotional condition?	
Ear/Hearing Problems?	Yes No		Information on this form may be shared with appropriate personnel for health and educational purposes.	
<b>Allergies:</b>	Yes No	List:	Student (Parent or Guardian if Student is under 18 years of age)	
<b>Athletes:</b> Have you ever been denied participation in sports due to health reasons?	Yes No		X _____ Signature Required Date	