

**Utica College Sports Medicine
Annual Health Update**

09 10 11 12

Name: _____ Sport(s): _____ Date: ___/___/___

UC Student ID # (9 digit) _____ DOB: ___/___/___ Year: So Jr Sr 5th

Home address/city: _____ Home phone: _____

Email _____ Cell phone: _____

Insur Co _____ ID# _____ Plan/grp _____ Phone _____

In the last year, have you had any of the symptoms? Explain below:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Dizziness, lightheadedness or passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain, irregular heartbeat, or heart palpitations while exercising? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Shortness of breath, cough, or trouble breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Muscle, bone or joint injury (current or lingering injury)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any surgeries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has your weight changed more than twenty pounds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any existing medical problems? (i.e. asthma, diabetes, allergies) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you developed any new medical problems (i.e. car accident)? | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all (prescription and over-the-counter) medications you are currently taking:

The above is true and accurate. Each student-athlete must have **insurance** to participate. You must notify the Athletic Training Staff of any insurance changes during the year.

Student Athlete Signature: _____ Date: ___/___/___

Sports Medicine Staff Use:

| | | | | |
|-----------------------------------|------------------------|---------------------------|------------------|--------|
| Date _____ | <i>Last year</i> _____ | <i>Current year</i> _____ | Ortho Scrn _____ | n/a |
| Form reviewed by: <i>BP</i> _____ | _____ | _____ | Waiver _____ | _____ |
| ATC _____ | <i>Pulse</i> _____ | _____ | Ins info _____ | school |
| Clinician _____ | <i>WT</i> _____ | _____ | Cleared by _____ | _____ |
| Other _____ | <i>HT</i> _____ | _____ | Date _____ | _____ |