

**GLACIER TWINS AMERICAN LEGION BASEBALL ATHLETIC PARTICIPATION QUESTIONNAIRE,
PHYSICAL EXAMINATION EVALUATION, AND PARENT OR GUARDIAN CONSENT AND RELEASE**

Athletic Participation Questionnaire (please print)

Player's Name _____ School _____ Grade _____
 Date of Birth ___/___/___ Home Address _____
 Phone 406-_____ Parent's Name _____
 Healthcare provider _____ Phone _____
Medical conditions, limitations, allergies, medications, etc. Please list any condition(s) that should be known to Twins Coach or supervisor. Include any medical history that a physician should be aware of in case of emergency treatment. _____

 Player's Signature _____ Date _____

Player's Health History

*Player and/or parent/guardian to fill out the following health history before physical examination.
Parent/guardian is required to sign consent and release on reverse side of this form after the examination.*

Has this player had any:	Yes	No	Is there a history of:	Yes	No
Chronic or recurrent illness	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring medical treatment	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Surgery (other than tonsillectomy)	<input type="checkbox"/>	<input type="checkbox"/>	Knee injury	<input type="checkbox"/>	<input type="checkbox"/>
Missing organs (eye, kidney, testicle)	<input type="checkbox"/>	<input type="checkbox"/>	Knee surgery	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to medications	<input type="checkbox"/>	<input type="checkbox"/>	Ankle injury	<input type="checkbox"/>	<input type="checkbox"/>
Problems with heart or blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other serious joint injury	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain with exercise	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones (fractures)	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Dizziness or fainting with exercise	<input type="checkbox"/>	<input type="checkbox"/>	Additional history:		
Frequent headaches, convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Is there any history of family or genetic diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Concussion or unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Has any family member died suddenly at less than 40 yrs of age of causes other than an accident?	<input type="checkbox"/>	<input type="checkbox"/>
Heat exhaustion/stroke, or other heat problems	<input type="checkbox"/>	<input type="checkbox"/>	Has any family member had a heart attack at less than 55 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
Any illness lasting over a week	<input type="checkbox"/>	<input type="checkbox"/>	Are you uncomfortably short of breath after running 1/2 mile (two times around the track) without stopping?	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis or anemia	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder/kidney infections in the past year	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Eyeglasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>			
Dental braces, bridges, plates	<input type="checkbox"/>	<input type="checkbox"/>			

List all medications the player is presently taking and what condition the medication is for:

1. _____
2. _____
3. _____

What is the most and least the player has weighed in the past year? Most _____ Least _____

Was there a medical problem/injury since player's last physical where three or more practices were missed? _____

Do you or the player have any questions you would like to ask the doctor? _____

Date of last known tetanus (lockjaw) shot: _____

Use separate piece of paper to explain any of the above numbered "YES" answers or to provide any additional information.

PHYSICAL EXAMINATION RECORD

To be completed by licensed Healthcare Professional. This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Player's Name _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____ / _____

Hemoglobin (optional) _____ UA (optional) _____

	<i>Normal</i>	<i>Abnormal Findings</i>
Eyes – Left ____ / 20 Right ____ / 20	<input type="checkbox"/>	_____
Pupils	<input type="checkbox"/>	_____
Ears, nose and throat	<input type="checkbox"/>	_____
Mouth and teeth	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	_____
Chest and lungs	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____
Genitals-Hernia	<input type="checkbox"/>	_____
Musculoskeletal: ROM, strength, etc.	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	_____

Comments regarding abnormal findings/recommendations: _____

Participation Recommendations:

- Full and unlimited participation
- Limited participation _____
- Clearance pending documented follow-up of: _____
- No athletic participation

Licensed Health Care Professional's Name (PRINT) *Date*

Signature *Phone Number*

Parent/Guardian Consent and Release

I hereby give my consent for the above player to participate in all activities sanctioned by Glacier Twins Baseball, except those indicated above by a licensed healthcare professional. I also give my permission for the Twins coach(es) or any other qualified personnel to give first aid treatment to this player at a baseball event in case of injury. If emergency service involving medical action or treatment is required and the parent(s) or guardian(s) cannot be contacted, I hereby consent for the player named above to be given medical care by the doctor or hospital selected by the Glacier Twins.

Parent or Guardian's Name (please print) *Address (print)*

Home phone *Insurance company*

Signature of Parent or Guardian *Date*