Name: **DOB:** **SEX:**

Fishburne Military School

Healthcare Providers

Primary Care Provider

Name _____

Phone number _____

Address _____

City _____

Sate/Province _____

Zip/Postal Code _____

Mental Health Questions

Have you ever been diagnosed with Depression, Anxiety, Bi-polar, ODD, ADD, or ADHD? Yes/No

If so, are you on any treatment medications ? Yes/No

Are you now, or have you in the past been in counseling for any reason? Yes/No

Have you ever been hospitalized for anything? Yes/No

Have you ever had thoughts of self-harm or suicide? Yes/No

Health History

Has a doctor ever denied or restricted your participation in sports for any reason? Yes/No

Have you ever spent a night in the hospital? Yes/No

Have you ever had surgery? Yes/No

Do you wear glasses or contact lenses? Yes/No

Have you had any problems with your eyes or vision? Yes/No

Have you had any eye injuries? Yes/No

Heart Health Questions

Have you ever passed out or nearly passed out DURING or AFTER exercise? Yes/No

Have you ever had discomfort, pain, tightness, or presser in your chest during exercise? Yes/No

Does your heart ever race or skip beats (irregular beats) during exercise? Yes/No

Has a doctor ever told you that you have high blood pressure?	Yes/No
Has a doctor ever told you that you have a heart murmur?	Yes/No
Has a doctor ever told you that you have high cholesterol?	Yes/No
Has a doctor ever told you that you have a heart infection?	Yes/No
Has a doctor ever told you that you have Kawasaki Disease?	Yes/No
Has a doctor ever told you that you have any other heart problemss?	Yes/No
Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram?)	Yes/No
Do you get lightheaded or feel more short of breath than expected during exercise?	Yes/No
Have you ever had an unexplained seizure?	Yes/No
Do you get more tired or short of breath more quickly than your friends during exercise?	Yes/No

Heart Health Questions About Your Family

Has any family member died of heart problems or died suddenly before age 50?	Yes/No
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?	Yes/No
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	Yes/No

Bone and Joint Questions

Have you ever had a bone or joint injury that caused you to miss a practice or a game?	Yes/No
Have you ever had any broken or fractured bones or dislocated joints?	Yes/No
Have you ever had an injury that required x-rays, MRI, CT scan, injections?	Yes/No
Have you ever had an injury that required therapy, a brace, a cast, or crutches?	Yes/No
Have you ever had a stress fracture?	Yes/No
Have you ever had an X-ray for neck instability or atlantoaxial instability?	Yes/No
Do you regulary use a brace, Orthotics, or other assistive device?	Yes/No

Do you have a bone, muscle, or joint injury that bothers you? Yes/No

Do any of your joints become painful, swollen, feel warm or look red? Yes/No

Do you have any history of juvenile arthritis or connective tissue disease? Yes/No

Mental, Emotional, and Social Health

Have you ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? Yes/No

Have you ever been treated for emotional or behavioral difficulties or an eating disorder? Yes/No

During the past twelve months have your seen a professional to address mental/emotional health concerns? Yes/No

Have you had a significant life event that continues to affect your life or the participant's life (abuse, death of a loved one or friend divorce, adoption, foster care, new sibling, survived a disaster?) Yes/No

Other Health Conditions

Asthma Yes/No
Diabetes Yes/No
Poliomyelitis Yes/No
Scarlet Fever Yes/No
Whooping Cough Yes/No
Recurrent Tonsillitis Yes/No
Tuberculosis Yes/No
Rheumatic Fever Yes/No
Anemia Yes/No
Sickle Cell Anemia Yes/No
Are there any additional conditions or diseases not listed on this form Yes/No

Medical Questions

General Health History

Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes/No

Have you ever used an inhaler or taken asthma medicine? Yes/No

Do you have epilipsy? Yes/No

Do you have a history of seizure disorder? Yes/No

Do you have kidney problems? Yes/No

Do you have migraines or frequent headaches? Yes/No

Have you ever received imPACT testing?	Yes/No
Have you ever received psychological treatment?	Yes/No
Have you ever been diagnosed with Hyperactivity/Attention Deficit?	Yes/ No
Have you ever had pneumonia?	Yes/No
Have you ever had a thyroid problem?	Yes/No
Have you ever had chicken pox?	Yes/No
Have you ever experienced fainting or diziness?	Yes/No
Have you had any recent or chronic infections?	Yes/No
Do you experience frequent sore throats?	Yes/No
Do you experience frequent or recurrent ear infections?	Yes/No
Do you experience frequent bronchitis?	Yes/No
Do you experience frequent nose bleeds?	Yes/No
Do you suffer from motion sickness?	Yes/No
Have you ever been diagnosed with scoliosis?	Yes/No
Do you have a hearing impairment?	Yes/No
Were you premature at birth?	Yes/No
Were there problems during your birth?	Yes/No
Have you ever had surgery?	Yes/No
Have you ever suffered from major injuries?	Yes/No
Have you ever suffered from muscle/skeletal injuries?	Yes/No
Have you ever had stomach problems?	Yes/No
Do you have a history of smoking?	Yes/No
Do you have a history of drug or alcohol use?	Yes/No
Have you ever participated in special educational testing?	Yes/No

Do you have any learning needs?	Yes/No
Have you ever had German Measles?	Yes/No
Have you ever had the Mumps?	Yes/No

Additional Health History

Is there anyone in your family who has asthma?	Yes/No
Are you missing any organs?	Yes/No
Do you have groin pain or a painful bulge or a hernia to the groin area?	Yes/No
Have you had infectious mononucleosis (mono) within the last month?	Yes/No
Do you have any rashes, pressure sores, or other skin prblems?	Yes/No
Have you ever had a herpes or MRSA skin infection?	Yes/No
Have you ever had a blow to the head that caused confusion, headache, or memory problems?	Yes/No
Do you have headaches with exercise?	Yes/No
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes/No
Have you ever been unable to move your arms or legs after being hit or falling?	Yes/No
Have you ever become ill while exercising in the heat?	Yes/No
Do you get frequent muscle cramps when exercising?	Yes/No
Do you or anyone in your family have sickle cell trait or disease?	Yes/No
Do you wear protective eyewear such as goggles or a face shield?	Yes/No
Do you worry about your weight	Yes/No
Are you trying to or has anyone recommended that you gain or lose weight?	Yes/No
Are you on a special diet or do you avoid certain types of foods?	Yes/No
Have you ever had an eating disorder?	Yes/No
Do you have any concerns that you would like to discuss with a doctor?	Yes/No

COVID-19 Exposure Risk

Has the studet traveled outside of the country or to one of the hot spots in the US in the last 14 Yes/No

Has the student had close contact with or cared for anyone diagnosed with COVID-19 within the ast 14 days? Yes/No

Has the student experienced any cold or flu-like symptoms in the last 14 days? (fever, cough, sore throat, respiratory illness, difficulty breathing?) Yes/No

Has the student had a confirmed positive test for COVID-19? Yes/No

Has the student been vaccinated for COVID-19? Yes/No

Additional Past and Current Health Issues

Is there any additional medical information that has not yet been addresses? Yes/No

I understand and agree to support Fishburne's policy that Cadets are not allowed to transport medications to or from Fishburne Military School or to be in possession of medication, to include over the counter medication, while at Fishburne Military School. Parents must deliver all medication to the Infirmary. Medications will be sent home during leave or furlough periods.

X _____

Parent or Guardian

NAME: