

## FIRST YEAR/TRANSFER INFORMATION LETTER

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

Dear Student:

You will be reporting for pre-season \_\_\_\_\_ training. Prior to  
(please list sport)

participation, your medical records will be reviewed and you may receive an additional medical evaluation before final clearance is granted. This process will be facilitated by your completing **Form I.**

Please be sure to answer **all** questions on Form I, **these questions pertain to your medical history over the past four years.** If you have had an injury or surgery, please include the date along with the specific injury/surgery.

If you answered **“Yes”** to any question on Form I **you must have Form II completed by the physician who treated you for the problem.**

To complete Form II, fill out the top of the form with your name, date of birth, medical problem, and release of information signature. It is not necessary that your physician see you unless he/she feels that a visit is necessary in order to update your medical status. Failure to comply with this request may delay your participation. If your physician must fill out a clearance form, it would be a courtesy to supply him/her with a stamped addressed envelope. Please return Form I, II:

**The Athletic Trainer, St. Lawrence University, Canton, NY 13617**

Sincerely yours,

Daniel R. Palmateer, M.D.

Medical Director

Student Health Services

ANNUAL HEALTH QUESTIONNAIRE – INTERCOLLEGIATE ATHLETICS

FIRST YEAR FORM

Name: \_\_\_\_\_ Class Year \_\_\_\_\_ SLU ID # \_\_\_\_\_
(Last) (First) (m.i)

Sport 1: \_\_\_\_\_ Sport 2: \_\_\_\_\_ Sport 3: \_\_\_\_\_

CIRCLE RESPONSE

A. IN THE LAST 4 YEARS HAVE YOU EXPERIENCED OR BEEN TREATED FOR:

- 1. LOSS OF CONCIIOUSNESS YES NO DATES \_\_\_\_\_
2. SKULL FRACTURE YES NO DATES \_\_\_\_\_
3. CONCUSSION YES NO DATES \_\_\_\_\_
4. POST CONCUSSION SYNDROME YES NO DATES \_\_\_\_\_
5. NECK OR SPINE INJURY YES NO DATES \_\_\_\_\_
6. CHEST PAIN YES NO DATES \_\_\_\_\_
7. RAPID HEART RATE YES NO DATES \_\_\_\_\_
8. BREATHING DIFFICULTIES YES NO DATES \_\_\_\_\_
9. FAINTING/DIZZINESS WITH ACTIVITY YES NO DATES \_\_\_\_\_
10. HIGH BLOOD PRESSURE YES NO DATES \_\_\_\_\_
11. DIABETES YES NO DATES \_\_\_\_\_
12. ASTHMA YES NO DATES \_\_\_\_\_
13. EATING DISORDER YES NO DATES \_\_\_\_\_
14. HAS ANYONE IN YOUR FAMILY UNDER THE AGE OF 45 DIED SUDDENLY DUE TO HEART PROBLEMS? YES NO
RELATIONSHIP: \_\_\_\_\_

B. IN THE LAST 4 YEARS HAVE YOU BEEN TREATED BY A DR. FOR:

- 1. MAJOR JOINT SPRAINS YES NO BODY PART \_\_\_\_\_
2. JOINT DISLOCATIONS YES NO BODY PART \_\_\_\_\_
3. SEVERE MUSCLE STRAINS YES NO BODY PART \_\_\_\_\_
4. FRACTURES YES NO BODY PART \_\_\_\_\_
5. NERVE RELATED DISORDERS YES NO BODY PART \_\_\_\_\_
6. MAJOR JOINT SURGERY YES NO BODY PART \_\_\_\_\_
7. HEAT RELATED ILLNESS YES NO DATES \_\_\_\_\_
8. SEIZURES YES NO DATES \_\_\_\_\_
9. MEDICAL SURGICAL PROCEDURES YES NO DATES \_\_\_\_\_
10. MAJOR BACTERIAL INFECTIONS YES NO DATES \_\_\_\_\_
11. INJURY TO ANY ORGANS YES NO BODY PART \_\_\_\_\_

C. IN THE LAST 12 MONTHS HAVE YOU BEEN TREATED BY A DR. FOR:

- 1. ATTENTION DEFICIT HYPERACTIVITY YES NO

D. IN THE LAST 12 MONTHS HAVE YOU BEEN ADVISED NOT TO PARTICIPATE IN ATHLETIC ACTIVITIES? YES NO

REASON: \_\_\_\_\_

I CERTIFY THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_