RETURNER INFORMATION LETTER

Date: ______________________

Dear Student:

You will be reporting for pre-season________________________ training. Prior to 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, they pertain to your medical status over the past 12 months. If you have had an injury or surgery within the past 12 months, 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 for this injury/surgery.

To complete Form II, fill out the top of the form with your name, injury or surgery, date of medical care and sport in which you will be participating. 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 to:

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

Sincerely,

Daniel R. Palmateer

Medical Director

Student Heath Services

ANNUAL HEALTH QUESTIONAIRE – INTERCOLLEGIATE ATHLETICS
UPPERCLASS FORM 1

Name: ____________________________________ Class Year _______ SLU ID #________________
(Last) (First) (m.i)

Sport 1:________________ Sport 2: _______________________Sport 3: ____________________

CIRCLE RESPONSE

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

1. LOSS OF CONCIOUSNESS 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___________

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

1. CHEST PAIN YES NO DATES___________
2. RAPID HEART RATE YES NO DATES___________
3. BREATHING DIFFICULTIES YES NO DATES___________
4. FAINTING/DIZZINESS WITH ACTIVITY YES NO DATES___________
5. HIGH BLOOD PRESSURE YES NO DATES___________
6. DIABETES YES NO DATES___________
7. ASTHMA YES NO DATES___________
8. EATING DISORDER YES NO DATES___________
9. HAS ANYONE IN YOUR FAMILY UNDER THE AGE OF 45 DIED SUDDENLY DUE TO HEART PROBLEMS? YES NO
   RELATIONSHIP:___________________________________

C. IN THE LAST 12 MONTHS, 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 _____________

D. IN THE LAST 12 MONTHS, HAVE YOU BEEN TREATED BY A DR. OR HOSPITAL FOR ANY OF THE FOLLOWING:

1. HEAT RELATED ILLNESS YES NO DATES__________________
2. SEIZURES YES NO DATES__________________
3. MEDICAL SURGICAL PROCEDURES YES NO BODY PART_____________
4. MAJOR BACTERIAL INFECTIONS YES NO DATES__________________
5. INJURY TO ANY ORGANS YES NO BODY PART _____________
6. ATTENTION DEFICIT HYPERACTIVE SYN. YES NO DATES___________

E. 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**