

Health Report

	_	Major:
STUDENT INFORMATION		
Name		
Last	First	Middle
Address		
Street Birth date//	City	State Zip □ Female □ Male
E-mail	Age C	Cell Ph # ()
EMERGENCY CONTACT INFORMA	ATION	
Name		
Last	First	Middle
Relationship		
vvork () E-mail)
E-IIIaii		Ceii Fii # ()
CONSENT FOR TREATMENT		
illness or injury, this is not always possible appropriate care. I, under 18), do authorize the Medical Staff at exercise for me and on my behalf, all right surgical treatment, anesthetics, medicines	within a short period of tin (Print Full Nate California Maritime Acadents and duties with reference and hospitalization, including	effort is made to contact families in the event of serious me; therefore, the consent form is necessary to provide lame of Student/Print Full name of Parent if child is my, upon appropriate medical or surgical consultation, to e to consenting to appropriate medical, psychiatric, and ng care and treatment, by any hospital, staff surgeon, ncy care of myself or my son/daughter (circle one).
Student's Signature		Date//
Parent's Signature (if applicable)		Date/
guarantee and will not be used as a fin U.S. Coast Guard. Please provide all fol registration This medical information is accessible or	nal determination for mee low-up information reques only to the professional st	cal record at Cal Maritime. Its content does not eting licensing physical requirements as set by the ested as soon as possible to avoid any delay in your taff of Student Health Services and Athletic Trainer
by law.		ent, a lawfully issued subpoena, and/or as specified ed is true and correct to the best of my knowledge,
and that I have not knowingly omitted to inform the CMA Student Health Services	report any material informs of any change of status of medication, recent	mation relevant to this form. I further attest that I will to my health condition once enrolled, including but surgery or hospitalization. Failure to do so may

"A CAMPUS OF THE CALIFORNIA STATE UNIVERSITY"

Address
CMA Student Health Services
200 Maritime Academy Drive
Vallejo, CA 94590-8181

Student's Signature: __

Phone 707-654-1170

Fax 707-654-1171 World Wide Web www.csum.edu/health

Current Medications: Medication Allergies:						
Check those of the following diseases or conditions that student has had:						
Check those of the following diseases or conditions that student has had: Yes No						
Check those of the following diseases or conditions that student has had: Yes No						
Yes No						
Speech Impediment						
Hearing Loss Disorders						
Loss of Memory						
Periods of Unconsciousness Learning Disorder Autistic Spectrum Disorder (ASD) Autistic Spectrum Disorder, or any other psychiatric diagnosis? Yes Not If, "Yes" please give specifics: (Note: Accurate reporting of all medical and psychiatric medications, including medication for ADD, and report the name and dosage of the medication on this form. Students applying to a licensed track program reporting a history of teament and/or medication for the above may be informed that they have a medical condition subject to further review by the US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard Incensing and to provide additional documentation of their condition at that time.) PLEASE DOCUMENT OR COMPLETE THE FOLLOWING IMMUNIZATIONS PRIOR TO ENROLLMENT MMR/MMRV #1						
Sleep Walking						
Impaired Balance or Coordination						
Blood Disease						
Heart or Vascular Disease						
High Blood Pressure						
Heart Surgery						
Orthopedic Problems						
Impaired Range of Motion						
Gastrointestinal Disorders Measles Mumps Other Infectious Disease Other Infectious Disease						
Renal Disease Chronic Headaches Recent or Repetitive Surgery Neurological Disorder Epilepsy, Seizure or Paralysis PSYCHIATRIC HISTORY (TO BE COMPLETED BY A PHYSICIAN) Does this patient have a history of depression, anxiety, ADD, Autistic Spectrum Disorder, or any other psychiatric diagnosis? Yes No If, "Yes" please give specifics: (Note: Accurate reporting of all medical and psychological conditions will ensure continuity of care. Students are encouraged to remain on any prescribed psychiatric medications, including medication for ADD, and report the name and dosage of the medication on this form. Students applying to a licensed track program reporting a history of treatment and/or medication for the above may be informed that they have a medical condition subject to further review by the US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard licensing and to provide additional documentation of their condition at that time.) PLEASE DOCUMENT OR COMPLETE THE FOLLOWING IMMUNIZATIONS PRIOR TO ENROLLMENT MMR/MMRV #1 Tetanus/TDAP (Within 5 years) #2						
□ □ Chronic Headaches □ □ Other Infectious Disease □ □ Recent or Repetitive Surgery □ □ Neurological Disorder □ □ Epilepsy, Seizure or Paralysis PSYCHIATRIC HISTORY (TO BE COMPLETED BY A PHYSICIAN) Does this patient have a history of depression, anxiety, ADD, Autistic Spectrum Disorder, or any other psychiatric diagnosis? □ Yes □ No If, "Yes" please give specifics: (Note: Accurate reporting of all medical and psychological conditions will ensure continuity of care. Students are encouraged to remain on any prescribed psychiatric medications, including medication for ADD, and report the name and dosage of the medication on this form. Students applying to a licensed track program reporting a history of treatment and/or medication for the above may be informed that they have a medical condition subject to further review by the US Coast Guard. They may be required to be off their medication for a period of time prior to, and continuously thereafter, US Coast Guard licensing and to provide additional documentation of their condition at that time.) PLEASE DOCUMENT OR COMPLETE THE FOLLOWING IMMUNIZATIONS PRIOR TO ENROLLMENT MMR/MMRV #1 Tetanus/TDAP (Within 5 years)						
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MMR/MMRV #1 Tetanus/TDAP (Within 5 years)						
#2						
#2						
Tuberculin Skin Test-Date Given						
Tuberculin Skin Test-Date Given						
(Within 6 months) Date Read Results						
Varicella (Chicken Pox) #1						
(Not needed if 2 MMRV on file) #2						
Meningococcal (Within 5 years)-Menomune						
Meningococcal (Within 5 years)-Menomune						
Or Menactra						
Or Menactra						

Student's Name:		DOB:	Student ID#: _			
PHYSICAL EXAMINATION (T	O BE COMPLETED	BY A PHYSICIAN)				
Blood Pressure: F	Pulse:	Height:	Weight:			BMI:
HEA	RING:					
□ Normal □ Abnormal* (attach *If abnormal, perform audiogram.	Audiogram)					
VISUAL ACUITY			PHYSICAL		T	
*Both uncorrected and corrected vision mu		Check each item in p Enter N.E. if not evalu		Normal	Abnormal	Note: Give details of each abnormality with
	RECTED VISION:	MEDIOAL				corresponding item #.
	Eye	MEDICAL				
			cation of Marfan syndrome	+	-	
Do you wear: Glasses ☐ Conta	act Lenses	Eyes/ears/nose/throat - Pupils equal and Hearing				
		Lymph nodes		+		
FIELD OF VISION*:		Heart - Murmurs and	location of PMI	_	-	
Degrees Normal		Pulses - Simultaneou	us femoral and radial pulses	_		
*Applicant must have 100° horizontal	field of vision	Lungs		\perp	-	
		Abdomen		_		
* Only one of the following USCG and	proved tests is	Genitourinary (males	only)			
* Only one of the following USCG approved tests is required. Please indicate which test was used. ☐ Pseudoisochromatic Plates (Dvonine, 2 nd , Ed.; AOC; revised edition or AOC/HHR; Ishihara 16, 24 or 38 plate)		Skin - HSV, lesions s	uggestive MRSA, tinea corporis			
		Neurologic				
		MUSCULOSKELE	TAL			
☐ Eldridge-Green Color Perception	Lantern	Neck				
☐ Farnsworth D15		Back				
 □ Farnsworth D15 □ Keystone Orthoscope or Telebinocular □ SAMCTT □ Titmus Optical Vision Tester □ Williams Lantern 		Shoulder/Arm				
		Elbow/forearm				
		Wrist/hand/fingers				
- williams Eartern		-		\dashv		
Does this individual have defective co	lor vision?	Hip/thigh Knee		-		
☐ Yes ☐ No	ioi violoii:	Kilee		+		
a res a No		Leg/ankle		\perp		
If yes, please explain extent of deficie	ncy:	Foot/toes		\perp	<u> </u>	
		Functional -Duck-wal	k, single leg hop			
Sp	orts Clearance 🗗		ports without restriction			
•		☐ Cleared for all s☐ Not cleared- Ch	ports with restriction			
Does this individual have the agility, stre			ts 🛘 For certain sports			
 → Participate in all physical activity? → Climb steep or vertical ladders 	☐ Yes ☐ No ☐ Yes ☐ No					
 → Maintain balance on a moving deck 	☐ Yes ☐ No		the history and physical examination, what y to meet the physical and emotional dem			
Pull heavy fire hoses up to 400' & have the ability to lift fully charged fire hoses?	□ Yes □ No		y to meet the physical and emotional defin			
→ Rapidly don an exposure suit?	☐ Yes ☐ No					
 → Step over door sills of 24" in height? → Open or close water tight doors that 	☐ Yes ☐ No☐ Yes ☐ No	Do you recommer	nd further investigation or treatment?			
may weigh up to 56 pounds?						
→ Wear a respirator?	☐ Yes ☐ No					
Limitations:						
Name of Examining Physician:			License	#:		
Signature:	PLEA	SE PRINT				
_		Dai.c.	і оюрноне #			
Address:street		CITY	STATE		ZIP C	ODE

ATHLETIC PREPARTICIPATION PHYSICAL EVALUATION **HISTORY FORM** Date of Exam ___ (Note: This form is to be filled out by the student and/or parents (if student is under age 18) prior to seeing the physician. Name _ _Date of Birth ___ _____ Age _____ Year _____ Sport (s) _____ Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking Do you have any allergies? 🗆 Yes 🗅 No If yes, please identify specific allergy: 🗅 Medicines 🗅 Pollens 🗅 Food 🗅 Stinging insects

Explain "Yes" answers below, Circle questions you don't know GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: \square Asthma \square Anemia \square Diabetes \square Infections			27. Have you ever used all illitater of taken astrilla medicine?		
Other:					
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are missing a kidney, an eye, a testicle		
			(males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
Does your heart ever race of skip beats (irregular beats) during		1	33. Have you had herpes or MRSA skin infection?	1	
exercise?					
Has a doctor ever told you that you have any heart problems? If so, check all that apply:			34. Have you ever had a head injury or concussion?		
☐ High blood pressure ☐ A heart murmur			35. Have you ever had a hit or blow to the head that caused confusion,	1	
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			prolonged headache, or memory problems?		
Nawasaki disease			36. Do you have a seizure disorder?		
ECG/EKG, echocardiogram?			oo. Do you have a soledio disorder.		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			37. Do you have headaches with exercise?		
11. Have you ever had an unexplained seizure?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Do you get more tired or short of breath more quickly than your friends during exercise?			39. Have you ever been unable to move your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO	40. Have you ever become ill while exercising in the heat?		
13. Has any family member or relative died of heart problems or had an			41. Do you get frequent muscle cramps when exercising?		
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?					
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy,			42. Do you or someone in your family have sickle cell trait or disease?		
long QT syndrome, short QT ayndrome, Brugada syndrome or			40 Hz		<u> </u>
catecholaminergic polymorphic ventricular tachycardia?			43. Have you had any problems with your eyes or vision?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			44. Have you had any eye injuries?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			45. Do you wear glasses or contact lenses?		
BONE AND JOINT QUESTIONS	YES	NO	46. Do you wear protective eyewear, such as goggles or a face shield?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon			47. Do you worry about your weight?		<u> </u>
that caused you to miss a practice or a game?			I I Do you won'y about your wongin:		
18. Have you ever had any broken or fractured bones or dislocated joints?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			49. Are you on a special diet or do you avoid certain types of foods?		
20. Have you ever had a stress fracture?		1	50. Have you ever had an eating disorder?	1	
Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			51. Do you have any concerns that you would like to discuss with a doctor?		
22. Do you regularly use a brace, orthotics, or other assistive device?			FEMALES ONLY		
23. Do you have a bone, muscle, or joint injury that bothers you?			52. Have you ever had a menstrual period?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			53. How old were you when you had your first menstrual period?		
Do you have any history of juvenile arthritis or connective tissue disease?			54. How many periods have you had in the last 12 months?		

20. Have you ever had a stress fracture?	50. Have you ever had an eating					
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25. Do you have any history of juvenile arthritis or connective tissue disease?	54. How many periods have yo	ods have you had in the last 12 months?				
Explain "yes" answers here						
I hereby state that, to the best of my knowledge, my answ	s to the above questions are comp	elete and correct.				
Signature of athlete	Signature of parent/guardian if student is under age 18)	Date	e			