11.

If yes, check appropriate box and explain below.

Has any family member been diagnosed with enlarged heart,

(dilated cardiomyopathy) hypertrophic cardiomyopathy, long QT syndrome, or other ion channelopathy (Brugada syndrome, etc.) Marfan's syndrome, or abnormal heart rhythm)?

Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?

Has a physician ever denied or restricted your participation in sports for any heart problems?

4. Have you ever had a head injury or concussion?

Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times?_____ When was the last concussion?

How severe was each one? (Explain below)

Have you ever had a seizure?

Do you have frequent or severe headaches?

Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?

- 5. Are you missing any paired organs?
- 6. Are you currently under a doctor's care for a speci c illness, injury or medical condition
- 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?
- 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?

Do you have seasonal allergies that require medical treatment?

- 9. Have you ever been dizzy during or a er exercise?
- 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?

16. Are you unsatis ed with your current weight?17. Do you feel stressed out?

18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?

19.

Name (Last, First)	Sex	_ Date of B	irth			
School Attending	Stud	Student ID		Grade		
Home Address	City	Zip _				
Parent/Guardian(s) Name		dmM4am1	cd	dmMl1d33n	Name	