

# What should I bring???

1. Athletes participating in the Frappier Accelerations Sports Training programs offered through All-Star Sports Training should bring the following items to their training sessions:

- First and foremost, please make sure to bring your completed health history questionnaire which is part of this document.
- Testing is performed on the initial training session. Since there will be some sprinting done outside on natural grass, it is highly advised that athletes bring a pair of outdoor cleats or spikes.
- On all other training days athletes should wear cross-training type sneakers. Sneakers should fit properly and be able to be tied tightly. Athletes should wear shorts and a t-shirt; you may also wish to bring a small towel and some water.
- We have a water fountain accessible to all athletes and sports/protein drinks are available for purchase.

2. Athletes attending one of All-Star Sports Camps multiple day camps can use the following list as a guide of what to bring. Depending on the time of year central Florida is generally warm, but during the winter time it can get a bit cold (30-40°). Please bring the appropriate clothing relative to the dates of your trip. Double check to make sure you have everything you will need, do not hesitate to call us if you have any questions. All bedding is provided.

- \_\_\_ All required waivers and questionnaires
- \_\_\_ Enough clothes for your stay (+ some extras)
- \_\_\_ Sneakers
- \_\_\_ Cleats
- \_\_\_ Pads or other athletic gear
- \_\_\_ Shower Towels
- \_\_\_ Sandals
- \_\_\_ Soap
- \_\_\_ Shampoo
- \_\_\_ Contact solution
- \_\_\_ Aspirin
- \_\_\_ Sun block
- \_\_\_ Bug/Mosquito repellent
- \_\_\_ Bathing suite
- \_\_\_ Medications
- \_\_\_ Medical insurance information
- \_\_\_ Extra cash or travelers checks for theme parks
- \_\_\_ Cell phone charger

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# All-Star Sports Training Health History Questionnaire Form

The information contained in this medical history form will only be used by All-Star Sports Camps for purposes of determining if you pose a health threat/risk to yourself during training. This information will remain confidential at all times.

## General Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sport(s) \_\_\_\_\_

## **PERMANENT ADDRESS:**

\_\_\_\_\_ STREET \_\_\_\_\_

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

E-mail: \_\_\_\_\_ (needed for AIMS registration)

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_\_ ) \_\_\_\_\_

## Medical Questions

If you answer **yes** to any of the following questions, please provide an explanation at the end of this section or on a separate sheet of paper.

**Please remember, all answers to the questions will remain confidential.**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have you ever had chest pain and/or shortness of breath, dizziness, lightheadedness, or passed out during or after exercise/practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice?                               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have you ever been told that you have a heart murmur?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Has any family member or close relative had heart problems and/or died of sudden death before the age of 50?                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems?                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Does anyone in your family have a history of high blood pressure or high cholesterol?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Are you presently taking or have you previously taken any allergy medications?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications, food, insect bites, or bee stings?           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever been diagnosed with asthma and/or exercised-induced asthma?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Are you presently taking or have you previously taken any asthma medications or used an inhaler?                                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please describe \_\_\_\_\_

11. If yes, then how many times do you use your rescue inhaler (e.g., Albuterol, Proventil, etc.) during an average week? \_\_\_\_\_

- |   |   |   |   |                                    |   |  |
|---|---|---|---|------------------------------------|---|--|
| 12. Do you suffer from headaches?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 | How often?  | <input type="checkbox"/> Every Day | <input type="checkbox"/> 1-2 Times/Week | <input type="checkbox"/> 1-2 Times/Month |
| 13. Have you ever experienced numbness and/or tingling in your arms/fingers?  | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 14. Have you ever suffered an injury to your shoulder/upper arm?  | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 15. Have you ever suffered an injury to your elbow/forearm?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 16. Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 17. Have you ever suffered an injury to your spine/low back/sacroiliac joint?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 18. Have you ever had numbness/tingling down one or both legs?  | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 19. Have you ever suffered an injury to your hip/groin (including hernias and/or sports hernias)?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 20. Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 21. Have you ever suffered an injury to your knee and/or patella (kneecap)?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 22. Have you ever suffered an injury to your ankle/lower leg/feet/toes?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 23. Do you presently  | <input type="checkbox"/> tape your ankle(s) | <input type="checkbox"/> use ankle brace(s) | <input type="checkbox"/> Other. Please describe _____ |                                    |   |  |
| 24. Have you ever suffered an injury to your rib/thorax/chest?  | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| 25. Have you ever suffered from a heat-related illness?   | <input type="checkbox"/> YES                | <input type="checkbox"/> NO                 |   |                                    |   |  |
| a. (check all that apply): <input type="checkbox"/> heat cramps/heat syncope (fainting)- <input type="checkbox"/> heat exhaustion- <input type="checkbox"/> heat stroke- <input type="checkbox"/> dehydration |   |   |   |                                    |   |  |

## Answers

If you have answered yes to any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Prescription Medications:

Please list all prescription and over-the-counter medications you are currently taking and for what purpose.

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Supplements / Ergogenic Aids:

Please list all supplements/ergogenic aids that you are currently taking or have taken in the past two (2) years and for what purpose.

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Medical History Statement

I have completed this medical history questionnaire and answered it to the best of my knowledge and truthfully. I am prepared to answer questions from All-Star Sports Camps staff (performance specialists, athletic trainers, and consultants) concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have **not disclosed** on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to All-Star Sports Camps staff and its Consultants as it may be a matter of life or death.

Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent Signature (if athletes is under 18 years of age):** \_\_\_\_\_

REVIEWED BY:

\_\_\_\_\_  
Reviewer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer's Name (Print)