SPORTS MEDICAL INFORMATION FORM
2015

To be completed by the athlete & parents

Last Name_______________________________ First Name_________________________

Address ____

City ________________________Province___________ Postal Code ________________

Home Phone # (   )________________ Cell Phone # (   )____________________

Date of Birth ______/_______/________
Day Month Year

Health Care # __________________________________ Province ______________________

IN CASE OF AN EMERGENCY WHOM CAN WE NOTIFY (in case we cannot contact you):

Name ______________________________________ Relationship _____________________

Address ____

Phone _______________________________

Family Doctor's Name ________________________________

Date of Last Physical __________________________
Month Year

Explain "Yes" answers below: Yes No

1. Have you ever been hospitalized?____
2. Have you ever had surgery?____
3. Are you presently taking any medications or pills?_______________________
4. Are you presently taking any vitamins or supplements?____________________
5. Do you have any allergies (medicine, bees or other stinging insects)?______________
6. Have you ever passed out during or after exercise?_______________________
7. Have you ever been dizzy during or after exercise?_______________________
8. Have you ever had chest pain during or after exercise?____________________
9. Have you ever had high blood pressure?________________________________
10. Have you ever been told that you have a heart murmur?__________________
11. Have you ever had racing of your heart or skipped heartbeats?______________
12. Has anyone in your family died of heart problems or a sudden death before age 50?___
13. Do you have any skin problems (itching, rashes, acne)?__________________
14. Have you ever had heat or muscle cramps?_____________________________
15. Have you ever been dizzy or passed out in the heat?_____________________
16. Do you have trouble breathing or do you cough during or after activity?__________
17. Do you use any special equipment (braces, mouth guard, eye guards, etc.)?_________
18. Do you use any dental appliances?_________________________________
19. Have you had any problems with your eyes or vision?____________________
20. Do you wear glasses or contacts or protective eyewear?__________________
21. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?__
22. Have you had a medical problem or injury since your last evaluation?_____________
23. Have you had any unexplained weight change?__________________________

24. When was your last tetanus shot? _____________________

25. When was your last measles immunization? ________________

Explain "Yes" answers (Indicate Question Number)

____

____

____

HEAD INJURIES / CONCUSSIONS:

Yes No

26. Have you ever had a seizure? ....
27. Have you ever had a head injury?..
28. Have you ever had a concussion or been "knocked out", had your "bell rung"? ....

If YES, please list: Number: ______
Date(s) Activity at the time Length of unconsciousness (minutes) Length of time before full return to Activity

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29. Did you have any persistent problems with:
Memory YES NO Dizziness YES NO Headaches YES NO
If YES, please indicate:
Date(s) Activity at the time Length of time sensation/strength changes persisted?

NECK INJURIES / BURNERS / STINGERS: **Yes No**

30. Have you ever had a neck injury (i.e., strain, sprain, fracture, etc.).......................................
31. Have you ever had a stinger, burner or pinched nerve?...
(a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - a.k.a. "brachial plexus stretch injury")
If YES, please list: Number: ______
Date(s) Activity at the time Length of time sensation/strength changes persisted?

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32. Check any of the areas that you have **INJURED IN THE PAST** and explain the injury below:

Hand ___ Elbow ___ Neck ___ Hip ___ Shin/Calf ___Wrist ___ Arm ___ Chest ___ Thigh ___ Ankle ___

Forearm ___ Shoulder ___ Back ___ Knee ___ Foot ___

Year of injury Type of Injury Side (right, left, both) Is it still a problem? (Yes/No)

____
____
____
____

Yes No

33. Do you have any incompletely healed injury? ....
If yes, which injury?

____

*** Your physician should check any medical condition or injury problem before participating in a sports program ***

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted; the team management will take me to the hospital/Medical Doctor if deemed necessary.

I hereby authorize the training staff/physician and nursing staff to undertake examination, investigation and necessary treatment.

I also authorize release of information to appropriate people (Coaches. Trainers, Physician) as deemed necessary by the Trainer.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete Signature ______________________________ Date________________

Parent/Guardian Signature ______________________________ Date ________________