SPORTS MEDICAL INFORMATION FORM 2015

Last Name First Name Address First Name Postal Code Home Phone # () Cell Phone # () Postal Code Home Phone # () Province Postal Code Phome # () Province First Name Relationship Address Phone Relationship Address Phone Family Doctor's Name Province Family Doctor's Name Province First Name Province Firs	To be completed by the athlete & pare	ents				
City	Last Name	First Name				_
Home Phone # () Cell Phone # () Date of Birth / Province	Address					
Date of Birth	City	Provinc	ce	Postal Code		
Health Care # Province IN CASE OF AN EMERGENCY WHOM CAN WE NOTIFY (in case we cannot contact you): Name Relationship Relationship Address Phone Barnily Doctor's Name Date of Last Physical Month Year Explain "Yes" answers below: 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 head high blood pressure? 10. Have you ever had racing of your heart or skipped heartbeats? 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 been dizzy or passed out in the heat? 15. Have you ever been dizzy or passed out in the heat? 16. Do you use any dental appliances? 17. Do you use any dental appliances? 18. 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 an edical problem or injury since your last evaluation? 23. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? 24. When was your last tetanus shot?	Home Phone # ()		Cell Phone # ()		
IN CASE OF AN EMERGENCY WHOM CAN WE NOTIFY (in case we cannot contact you): Name	Date of Birth/	/Year	-			
Name	Health Care #			Province		
Address	IN CASE OF AN EMERGENCY	WHOM CAN	N WE NOTIFY (ii	n case we cannot conta	act you):	
Phone	Name		Re	ationship		-
Phone	Address					
Date of Last Physical						
Date of Last Physical	Family Doctor's Name					
Explain "Yes" answers below: 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 medications 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 had chest pain during or after exercise? 9. Have you ever had high blood pressure? 10. Have you ever had high blood pressure? 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 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 any unexplained weight change? 24. When was your last tetanus shot? 25. When was your last measles immunization?				-		
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 any unexplained weight change? 23. Have you had any unexplained weight change? 24. When was your last tetanus shot?	Month Year					
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 had racing of your heart or skipped heartbeats? 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 any unexplained weight change? 23. Have you had any unexplained weight change? 24. When was your last tetanus shot?		zed?				No
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.)? 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 any unexplained weight change? 24. When was your last tetanus shot? 25. When was your last measles immunization?	Have you ever had surgery?_					
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 any unexplained weight change? 23. Have you had any unexplained weight change? 24. When was your last tetanus shot?						
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?	6. Have you ever passed out du	ring or after	s or other stinging exercise?	g insects)?		
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?	Have you ever been dizzy du:	ring or after e	exercise?			
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?	Have you ever had chest pair	n during or af	ter exercise?			
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?						
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?						
14. Have you ever had heat or muscle cramps?	12. Has anyone in your family of	led of heart p	rashes, acre)?	den death before age	50?	
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?	14. Have you ever had heat or n	nuscle cram	18311es, acrie):_			
16. Do you have trouble breathing or do you cough during or after activity?	15. Have you ever been dizzy or	r passed out	in the heat?			
17. Do you use any special equipment (braces, mouth guard, eye guards, etc.)?	16. Do you have trouble breathing	ng or do you	cough during or	after activity?	-	
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?	17. Do you use any special equi	ipment (brace	es, mouth guard,	eye guards, etc.)?		
20. Do you wear glasses or contacts or protective eyewear?	18. Do you use any dental applic	ances?				
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?	19. Have you had any problems	with your ey	es or vision?			
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?	20. Do you wear glasses or cont	tacts or prote	ective eyewear?_	nonuclassia dishetas	-t- \0	
23. Have you had any unexplained weight change?	22. Have you had any other med	blem or injur	v since vour last	evaluation?	eic.)?	
24. When was your last tetanus shot? 25. When was your last measles immunization?	23. Have you had any unexplain	ned weight ch	nange?	Ovaladion		
Explain "Yes" answers (Indicate Question Number)	25. When was your last measles	s immunizatio	on?			
	Explain "Yes" answers (Indicate	Question Nu	ımber)			

HEAD INJURIES / CONCUSSIONS:	Yes No			
26. Have you ever had a seizure?				
f YES, please list: Number: Date(s) Activity at the time Length of unconsciousness (minutes) Length of time before full return to Activity				
29. Did you have any persistent problems with: Memory YES NO Dizziness YES N If YES, please indicate: Date(s) Activity at the time Length of time sensation/streng				
NECK INJURIES / BURNERS / STINGERS: 30. Have you ever had a neck injury (i.e., strain, sprain, 31. Have you ever had a stinger, burner or pinched ner (a burning or numb feeling in the shoulder or arm after a hit to the head If YES, please list: Number: Date(s) Activity at the time Length of time sensation/streng	Ve?			
32. Check any of the areas that you have INJURED IN	THE PAST and explain the injury below:			
Hand Elbow Neck Hip Shin/CalfV	Vrist Arm Chest Thigh Ankle			
Forearm Shoulder Back Knee Foot _	_			
Year of injury Type of Injury Side (right, left, both) Is it s	till a problem? (Yes/No)			
33. Do you have any incompletely healed injury? If yes, which injury?	Yes No			
*** Your physician should check any medical condition program ***	on or injury problem before participating in a sports			
I understand that it is my responsibility to kee above information as soon as possible and that in the will take me to the hospital/Medical Doctor if deemed				
I hereby authorize the training staff/physician investigation and necessary treatment.	and nursing staff to undertake examination,			
I also authorize release of information to apprehend necessary by the Trainer.	ropriate people (Coaches. Trainers, Physician) as			
I hereby state that, to the best of my knowledge, and correct.	my answers to the above questions are complete			
Athlete Signature	Date			
Parent/Guardian Signature				