

SPORTS MEDICAL INFORMATION FORM 2014

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

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever had a concussion or been "knocked out", had your "bell rung"? | <input type="checkbox"/> | <input type="checkbox"/> |

If 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 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?

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 _____