Athlete Medical Information Form

(To be filled out by parent or guardian)

Name:

Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ (DD/MON/YEAR)

Address:

Sport/Activity:

Alberta Health Care Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_

Height: Weight:

Family Doctor’s Name:

Family Doctor’s Address:

Family Doctor’s Phone Number:

Please circle the appropriate response below pertaining to this person:

Yes No Previous history of concussions

Yes No Fainting episodes during exercise

Yes No Epileptic

Yes No Wears glasses

Yes No Lenses shatterproof

Yes No wears contact lenses

Yes No Wears dental appliance

Yes No Hearing problem

Yes No Asthma, tuberculosis, or bronchitis

Yes No Trouble breathing during exercise

Yes No Heart condition of rheumatic fever

Yes No High or low blood pressure

Yes No Anemia, leukemia, or bleeding disorder

Yes No Diabetes, hepatitis, or jaundice

Yes No Kidney or bladder problems

Yes No Hernia (rupture)

Yes No Mental illness or nervous breakdown

Yes No Illness lasting more than a week in the past year

Yes No Wears medic alert jewelry

Yes No Surgery in the last year

Yes No Hospitalized in the last year

Yes No Injuries requiring medical attention in the last year

Yes No presently injured

Yes No Any other health problems that may interfere with participation

Please give details below if you answered yes to any of the questions on the previous page. (Use a separate sheet if necessary).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

Allergies:

Medical Conditions:

Recent Injuries:

Last Tetanus Shot:

Any other information not covered above:

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