



## Player Medical Information - 2012

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
 Home/Cell: \_\_\_\_\_ Home/Cell: \_\_\_\_\_  
*Other person to contact in case of accident/emergency*  
 Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Past Medical History: Have you had any of the following?

Heart Murmur	Yes	No	Concussion	Yes	No
Heat Exhaustion	Yes	No	Asthma	Yes	No
Dizziness or Fainting with exercise	Yes	No	Past Surgery or Hospitalization	Yes	No
Chest pain or palpitations	Yes	No	Other Medical Problems	Yes	No
Have you ever been restricted from sports participation for a medical problem?				Yes	No
IF YES TO ANY OF THE ABOVE – PLEASE EXPLAIN IN HERE					

### Immunization

Are your immunizations up-to-date (e.g. tetanus, hepatitis)? **YES NO**

### Nutrition

Do you use energy drinks? (red bull, rock star, etc.)? **YES NO**

### Dental/Medical Aids

Do you wear glasses?	Yes	No	During Sport?	Yes	No
Do you wear contacts?	Yes	No	During Sport?	Yes	No
Do you use any other sensory aids (e.g. hearing)?	Yes	No	Explain:		

### Medications and Allergies

Have you taken ANY prescription medications or other substances in the past 3 months? **YES NO**

SUBSTANCE (drug name)	REASON (e.g. asthma)	PAST 3 MONTHS Yes/No	CURRENT Yes/No

Do you have any significant food, environmental or medical drug allergies? **YES NO**

SUBSTANCE	LAST EPISODE	TYPE OF REACTION
i.e. penicillin	Childhood or 2010	Rash/vomit VS anaphylaxis

## Musculoskeletal Injury History

Past Injury	Year	L or R	Diagnosis (if known)	Seen by? MD? Therapist?	Treatment	Still a Problem (Yes/No)
Hand						
Wrist						
Forearm						
Elbow						
Upper Arm						
Shoulder						
Collarbone						
Neck						
Ribs/Chest						
Back Upper/Lower						
Hip						
Thigh						
Knee						
Ankle						
Foot						

Please use this space to expand on any questionnaire items or for issues you feel we should know:

Any medical condition or injury problem should be checked by your physician before participating in a football 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 that no one can be contacted, team management will take my child to hospital/physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, assessment and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_