



DELBURNE MINOR HOCKEY MEDICAL FORM

To be completed by the athlete

Last Name _____ First Name _____

Address _____ City _____ Province _____

Date of Birth _____ Home Phone # (_____) _____ Postal Code _____
Day Month Year

Health Care # _____ Province _____

FOR EMERGENCY NOTIFY: Name _____ Relationship _____

Address _____ Phone _____

Family Doctor's Name _____ Date of Last Physical _____
Month Year

Sport: _____

Year of Participation in Sport (circle): 1st 2nd 3rd 4th 5th 6th

Year of Participation in Hockey (circle): 1st 2nd 3rd 4th 5th 6th

What position will you be playing this year? _____

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?.....	0	0
Have you ever had surgery?.....	0	0
2. Are you presently taking any medications or pills?	0	0
Are you presently taking any vitamins or supplements?	0	0
3. Do you have any allergies (medicine, bees or other stinging insects)?	0	0
4. Have you ever passed out during or after exercise?	0	0
Have you ever been dizzy during or after exercise?	0	0
Have you ever had chest pain during or after exercise?.....	0	0
Do you tire more quickly than your friends during exercise?	0	0
Have you ever had high blood pressure?	0	0
Have you ever been told that you have a heart murmur?	0	0
Have you ever had racing of your heart or skipped heartbeats?	0	0
Has anyone in your family died of heart problems or a sudden death before age 50?	0	0
5. Do you have any skin problems (itching, rashes, acne)?.....	0	0
6. Have you ever had heat or muscle cramps?	0	0
Have you ever been dizzy or passed out in the heat?	0	0
7. Do you have trouble breathing or do you cough during or after activity?	0	0
8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?.....	0	0
Do you use any dental appliances?	0	0
9. Have you had any problems with your eyes or vision?	0	0
Do you wear glasses or contacts or protective eye wear?	0	0
10. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	0	0
11. Have you had a medical problem or injury since your last evaluation?.....	0	0
12. Have you had any unexplained weight change?	0	0
13. When was your last tetanus shot? _____		
When was your last measles immunization? _____		
14. Female Athletes: Over the past year, did your periods occur about once a month?	0	0

Explain "Yes" answers

(Over ?)

HEAD INJURIES / CONCUSSIONS:

- | | | |
|---|-----|----|
| | Yes | No |
| 15. Have you ever had a seizure? | 0 | 0 |
| 16. Have you ever had a head injury? | 0 | 0 |
| Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"? | 0 | 0 |

If YES, please list: Number: _____

<u>Date(s)</u> <u>activity</u>	<u>Activity at the time</u>	<u>Length of unconsciousness (minutes)</u>	<u>Length of time before full return to activity</u>
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Did you have any persistent problems with:

memory YES NO	dizziness YES NO	headaches YES NO
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NECK INJURIES / BURNERS / STINGERS:

- | | | |
|--|-----|----|
| | Yes | No |
| 17. Have you ever had a neck injury (ie, strain, sprain, fracture, etc.) | 0 | 0 |
| 18. Have you ever had a stinger, burner or pinched nerve? | 0 | 0 |
- (a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - aka. "brachial plexus stretch injury")

If YES, please list: Number: _____

<u>Date(s)</u>	<u>Activity at the time</u>	<u>Length of time sensation/strength changes persisted?</u>
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19. 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 ___

<u>Year of injury</u>	<u>Type of Injury</u>	<u>Side (right, left, both)</u>	<u>Is it still a problem? (Yes/No)</u>
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- | | | |
|---|-----|----|
| | Yes | No |
| 20. Do you have any incompletely healed injury? | 0 | 0 |

If yes, which injury? _____

I hereby certify the above information to be correct.

Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____