FAIRVIEW MINOR HOCKEY ASSOCIATION MEDICAL FORM

PLAYER INFORMATION (Please Print)

LAST NAME	FIRST NAME	GENDER (CIRCLE) F M
STREET ADDRESS (NO PO BOX PLEASE)	TOWN	POSTAL CODE
MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)	LEGAL LAND DESCRIPTION (IF APPLICABLE)	DATE OF BIRTH _____ / _____ / _____ MM DD YYYY
HOME PHONE	CELL PHONE	AB HEALTH CARE #

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	RELATIONSHIP TO PLAYER
HOME PHONE	WORK PHONE	CELL PHONE
FAMILY DOCTOR'S NAME	PHONE	DATE OF LAST PHYSICAL
FAMILY DENTIST'S NAME	PHONE	

PLEASE ADVISE YOUR COACH, TEAM MANAGER AND FMH EXECUTIVE OF ANY HEALTH RESTRICTIONS

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
	Have you ever had surgery?	☐	☐
2.	Are presently taking any medications or pills?	☐	☐
	Are presently taking any vitamins or supplements?	☐	☐
3.	Do you have any allergies? (medications, bees, etc)	☐	☐
	If yes, please list: _____		
4.	Have you ever passed out during or after exercising?	☐	☐
	Have you ever been dizzy during or after exercising?	☐	☐
	Have you ever had chest pain during or after exercising?	☐	☐
	Do you tire more quickly than your friends during exercise?	☐	☐
	Have you ever had high blood pressure?	☐	☐
	Have you ever been told that you have a heart murmer?	☐	☐
	Have you ever had racing of your heart or skipped heart beats?	☐	☐
	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
5.	Do you have any skin problems (itching, rashes or acne)?	☐	☐
6.	Have you ever had heat or muscle cramps?	☐	☐
	Have you ever been dizzy or passed out in the heat?	☐	☐
7.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
8.	Do you use any special equipment (pads, braces, eye guards, etc)?	☐	☐
	Do you use any dental appliances?	☐	☐
9.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear eyeglasses, contacts or protective eye wear?	☐	☐
10.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc)?	☐	☐
11.	Have you had a medical problem or injury since your last medical?	☐	☐
12.	Have you had any unexplained weight change?	☐	☐

13. When was your last tetanus shot? _____ / _____ / _____
Month Day Year

14. When was your last measles immunization? ? _____ / _____ / _____
Month Day Year

HEAD INJURIES/ CONCUSSION

		YES	NO
15.	Have you ever had a seizure? ……	☐	☐
16.	Have you ever had a head injury? ……	☐	☐
	Have you ever had a concussion or been "knocked out", "bell rung" or been "dinged"? ……	☐	☐

If yes, please list: Number of occurrences: _____.
Date(s): _____.
Activity at time of injury: _____.
Length of Unconsciousness (minutes): _____.
Length of time before full return to activity: _____.

Did you have persistent problems with: Memory?.....
Dizziness? ……
Headaches? ……

NECK INJURIES/ BURNERS/ STINGERS:

		YES	NO
17.	Have you ever had a neck injury (ie strain, sprain, fracture, etc.)? ……	☐	☐
18.	Have you ever had a stinger, burner or pinched nerve? ……	☐	☐
	Have you ever had a burning or numb felleing in the shoulder or arm after a hit to the head, neck or shoulder (aka Brachial plexus stretch injury)	☐	☐

If yes, please list: Number of occurrences: _____.
Date(s): _____.
Activity at time of injury: _____.
Length of sensation/ strength changes persisted_____.
Length of time before full return to activity: _____.

Check any of the areas that you have INJURED IN THE PAST and explain the injury below

☐ Hand	☐ Hip	☐ Arm	☐ Ankle	☐ Back
☐ Elbow	☐ Shin/ Calf	☐ Chest	☐ Forearm	☐ Knee
☐ Neck	☐ Wrist	☐ Thigh	☐ Shoulder	☐ Foot

Year of injury: _____.
Type of injury: _____.
Side (Left/Right/Both): _____.
Length of time before full return to activity: _____.

	YES	NO
Is it still a problem? ……	☐	☐

Explain injury: _____
_____
_____
_____

		YES	NO
19.	Do you have any incompletely healed injuries? ……	☐	☐

If yes, which injury? _____.

I hereby certify the above information to be correct.

PLAYER NAME (PRINT)	PLAYER SIGNATURE	DATE
PARENT NAME (PRINT)	PARENT SIGNATURE	DATE
PARENT NAME (PRINT)	PARENT SIGNATURE	DATE