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

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?	☐	☐
27. Have you ever had a head injury?.....	☐	☐
28. Have you ever had a concussion or been "knocked out", had your "bell rung"?	☐	☐

If YES, please list: Number: _____
Date(s) Activity at the time Length of unconsciousness (minutes) Length of time before full return to Activity

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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?	☐	☐

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 _____