DELBURNE MINOR HOCKEY MEDICAL FORM

To be completed by the athlete

Last Name _______________________________ First Name_____________________________

Address ____ City_____________________________

Date of Birth_________________________ Phone # __________________ Postal Code ___________________

Day Month Year

Family Doctors Name _____________________________

FOR EMERGENCY NOTIFY: Name _______________________________ Relationship_________________________

Phone________________________________

Sport:____

	Yes	No
Have you ever been hospitalized?	o	o
Have you ever had surgery?	o	o
Are you presently taking any medications or pills?	o	o
Do you have any allergies	o	o
Have you ever passed out during or after exercise?	o	o
Have you ever been dizzy during or after exercise?	o	o
Have you ever had chest pain during or after exercise?	o	o
Do you tire more quickly than your friends during exercise?	o	o
Have you ever had high blood pressure?	o	o
Have you ever been told that you have a heart murmer?	o	o
Have you ever had racing of your heart or skipped heartbeats?	o	o
Has anyone in your family died of heart problems or a sudden death before age 50?	o	o
Do you have any skin problems (itching, rashes, acne)?	o	o
Have you ever had heat or muscle cramps?	o	o
Have you ever been dizzy or passed out in the heat?	o	o
Do you have trouble breathing or do you cough during or after activity?	o	o
Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	o	o
Do you use any dental appliances?	o	o
Have you had any problems with your eyes or vision?	o	o
Do you wear glasses or contacts or protective eye wear?	o	o
Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	o	o
Have you had any unexplained weight change?	o	o

When was your last tetanus shot? ___________________________

When was your last measles immunization? ______________________

Explain "Yes"answers

____

____

____

____

HEAD INJURIE / CONCUSSION Yes No

Have you ever had a seizure?.. o o

Have you ever had a head injury? .... o o

Have you ever had a concussion or been “knocked out”, had your “bell rung”, or been “dinged”?........................... o o

If YES, please list: Number: ______

Date(s) Activity at the time Length of unconsciousness (minutes) Length of time before full return to activity

Did you have any persistent problems with?

Memory YES NO Dizziness YES NO Headaches YES NO

NECK INJURIES / BURNERS / STINGERS: **Yes No**

Have you ever had a neck injury (ie, strain, sprain, fracture, etc.) .... o o

Have you ever had a stinger, burner or pinched nerve?... o o

If YES, please list: Number: ______

Date(s) Activity at the time Length of time sensation/strength changes persisted?

____

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 ___

Year of injury Type of Injury Side (right, left, both) Is it still a problem? (Yes/No)

____
____
____
____

Yes No

Do you have any incompletely healed injury?... o o

If yes, which injury?____

I hereby certify the above information to be correct

Athlete Signature ____ Date ____________________

Parent/Guardian Signature _______________________________________ Date ____________________