EPMH MEDICAL FORM

*** All Registrants must fill one out and hand in with registration

To be completed by the athlete:

Last Name _____First Name _____

Address _____City_____ Province _____ Postal Code _____

Date of Birth (Day Month Year) _____ Home Phone # _____ Health Care # _____

FOR EMERGENCY NOTIFY:

Name_____ Relationship_____ Phone_____

Family Doctor's Name _____Date of Last Physical (Month Year) _____

Sport: Minor Hockey Level (circle): U7(Initiation) U9(Novice) U11(Atom) U13(Peewee) U15(Bantam) U18(Midget)

Years of Participation in Sport: _____What position will you be playing this year? _____

Circle Yes or No Explain "Yes" answers below:

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

_____

HEAD INJURIES / CONCUSSIONS:

29. Have you ever had a seizure? YES NO
30. Have you ever had a head injury? YES NO
31. Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"? YES NO
32. 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:

33. Have you ever had a neck injury (i.e., strain, sprain, fracture, etc.)? YES NO
34. Have you ever had a stinger, burner or pinched nerve? YES NO
    (a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - aka. "brachial plexus stretch injury")
35. If YES, please list: Number: _____

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

OTHER INJURIES:

36. 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)	Side (right, left, both)	Is it still a problem? (Yes/No)

37. Do you have any incompletely healed injury? YES NO
    If yes, which injury? _____

I hereby certify the above information to be correct.

Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____