



MEDICAL FORM FOR LACROSSE ATHLETES

To be completed by the athlete and/or parent

Last Name: _____ First Name: _____
 Address: _____ City/Prov: _____
 Postal Code: _____ Phone #: () _____ cell home (circle)
 Date of Birth: _____
 Day Month Year

Health Care #: _____ Province: _____

FOR EMERGENCY NOTIFY:

Name: _____ Relationship: _____
 Address: _____ Phone: _____
 Family Doctor's Name: _____ Date of Last Physical: _____

Please check the appropriate response below pertaining to your child:

YES NO

- Previous history of concussions
- Fainting episodes during exercise
- Epileptic
- Wears glasses
- Are lenses shatterproof?
- Wears contact lenses
- Wears dental appliance
- Hearing problem
- Had injuries requiring medical attention in the past year
- Had an illness lasting more than a week in the past year
- Has a health problem that would interfere with participation on a lacrosse team

YES NO

- Diabetic
- Medication
- Allergies
- Wears a medic alert bracelet/necklace
- Surgery in the last year
- Has been in hospital in last year
- Presently injured
- Asthma
- Trouble breathing during exercise
- Heart condition

Please give details below if you answered "Yes" to any of the above items. Use separate sheet if necessary.

Please provide details related to the following items for your child:

Medications:

Allergies:

Medical Conditions:

Date of Last Tetanus Shot:

Date of last complete physical exam:

Describe any recent or relevant injuries (ie. Hand, wrist, shoulder, foot, ankle, back, etc.) for your child and explain injury below:

Describe any head injury or concussion for your child and explain injury below:

If YES, please list: Number: _____

Date	Activity at the time	Length of time to full return to activity (days or weeks)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does she have any persistent problems with memory, dizziness or headaches? **YES** **NO**

Any information not covered above:

Any medical condition or injury problem should be checked by your physician before participating in a lacrosse program.

I certify the above information to be correct.

I also understand it is my responsibility to keep the team management advised of any change in the above information as soon as possible.

In the event no one can be contacted, team management will take my child to hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination investigation and necessary treatment of my child.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Athlete Signature _____

Date _____

Parent/Guardian Signature _____

Date _____