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		YES	NO	
□	□	Previous history of concussions	□	□	Diabetic
□	□	Fainting episodes during exercise	□	□	Medication
□	□	Epileptic	□	□	Allergies
□	□	Wears glasses	□	□	Wears a medic alert bracelet/necklace
□	□	Are lenses shatterproof?	□	□	Surgery in the last year
□	□	Wears contact lenses	□	□	Has been in hospital in last year
□	□	Wears dental appliance	□	□	Presently injured
□	□	Hearing problem	□	□	Asthma
□	□	Had injuries requiring medical attention in the past year	□	□	Trouble breathing during exercise
□	□	Had an illness lasting more than a week in the past year	□	□	Heart condition
□	□	Has a health problem that would interfere with participation on a lacrosse team			

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 _____