



Medical Form

Surname: _____ Given Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone#: _____ Alternate #: _____

Birthdate: _____ Care Card #: _____

Emergency Contact Information

Name: _____ Relationship: _____

Contact Number: _____ Alternate #: _____

Doctor Name: _____ Medical Clinic Name: _____

Address: _____

Phone #: _____

Medical History

Do you wear contacts? YES NO

Do you have any allergies? YES NO

If yes, what are they?

Have you been hospitalized in the last 6 months? YES NO

If yes, what for?

Have you ever sustained any injuries to you Knees, Ankles, Elbows, wrists or shoulders that required medical attention? YES NO

If yes, please describe each injury and treatment?



Have you ever sustained a concussion? YES NO

If yes, please list when, in which sport, the degree of the concussion and the recovery time:

Trainer's information

Do you require any joint or area of the body taped? YES NO

If yes, please list below the area:

Do you require any specific area stretched or massaged before the game or practice? YES NO

Please list area below:

I have answered all questions accurately and completely as possible. I am aware that my failure to complete this form or provide inaccurate information, may delay my participation in practices and games. I also understand that I participate in the sports of lacrosse at my own will, I understand the inherent dangers of the sport, and not every injury is preventable. The medical staff is also held harmless for any action taken to aid and assist my health and well-being.

Athlete's signature

Date

In case of travel where the parent or guardian is not present, this form is to act as a medical release in case of serious injuries where immediate medical attention is required.

Parent/ Guardian Signature

Date