Player Medical History Form

PERSONAL INFORMATION

Name:	______________	Parent/Guardian Name:	______________
Address:	______________	Parent/Guardian Name:	______________
City:	______________	Emergency Contact Person:	______________
Postal Code:	______________	Emergency Contact #:	______________
Home #:	______________	Relationship to Player:	______________
Cell #:	______________	Health Card #:	______________
Sex (circle):	Male I Female	Extended Insurance Policy #:	______________
Date of Birth:	______________	Family Physician:	______________
	DD / MM / YYYY	Physician's Phone #:	______________

RECORD OF ILLNESS / INJURY

Circle those which have occurred at any time:	Seizures	Chest Pain	Recurring Headache	Blackouts
Do you suffer from any of the following? (circle)	Asthma	Diabetes	Heart Disease	
Do you require the use of corrective lenses? (circle)	Yes	No		
Do you wear contact lenses? (circle)	Yes	No		
Do you have any allergies? (circle)	Yes	No	Specify:	

List and provide details for any regular medication:

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Any additional information:

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If any of this information changes it is the responsibility of the parent(s)/guardian(s) to notify the coaching staff.

Date of Completion: ____________________

Parent/Guardian Signature: ______________________________