Queen City United Soccer Club

Health History Form

Athlete's Name: _____
First Middle Initial Last

Date of Birth: Month: ___ Day: _____ Year: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____)_____

Athlete's Health Card Number: _____

Parent/Guardian #1: Name: _____

Cell: (_____) _____

Parent/Guardian #2: Name: _____

Cell: (_____) _____

Alternate emergency contact (if parents/guardians are not available)

Name: _____

Relationship to player: _____

Telephone: (_____) _____ Cell: (_____)_____

Athlete's Doctor's Name: _____

Telephone: (_____) _____

Athlete's Dentist's Name: _____

Telephone: (_____) _____

Date of last complete physical examination: _____

Before an athlete participates in a soccer program, it is recommended they have a medical and have any medical condition(s) or injury problems checked by their family physician.

Please check the appropriate response and provide details below if you answer "Yes to any of the questions.

Yes ☐	No ☐	Medication
Yes ☐	No ☐	Allergies
Yes ☐	No ☐	Previous history of concussions
Yes ☐	No ☐	Fainting or seizure during or after physical activity
Yes ☐	No ☐	Near fainting or Brownouts
Yes ☐	No ☐	Seizures and/or epilepsy
Yes ☐	No ☐	Wears glasses
Yes ☐	No ☐	Are the lenses shatterproof
Yes ☐	No ☐	Wears contact lenses
Yes ☐	No ☐	Wears dental appliance
Yes ☐	No ☐	Hearing problem

Yes ☐	No ☐	Asthma
Yes ☐	No ☐	Trouble breathing during exercise
Yes ☐	No ☐	Heart Condition
Yes ☐	No ☐	Palpitations or Racing Heart
Yes ☐	No ☐	Family history of heart disease
Yes ☐	No ☐	Family history of unexpected death during physical activity
Yes ☐	No ☐	Family history of unexplained death of a young person
Yes ☐	No ☐	Diabetes – Type 1 _____ Type 2 _____
Yes ☐	No ☐	Wears medical information bracelet/necklace

For what purpose? _____

Yes ☐	No ☐	Health problem that would interfere with participation on a soccer team
Yes ☐	No ☐	Has an illness that lasted more than a week and required medical attention in the past year
Yes ☐	No ☐	Has had injuries requiring medical attention in the past year
Yes ☐	No ☐	Been admitted to hospital in the last year
Yes ☐	No ☐	Surgery in the past year
Yes ☐	No ☐	Presently injured

Injured body part: _____

Yes ☐	No ☐	Vaccinations up to date

Date of last tetanus shot: _____

Yes ☐	No ☐	Hepatitis B vaccination

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

_____

_____

_____

Medications: _____

Allergies: _____

Medical conditions: _____

Recent Injuries: _____

Any information not covered above: _____

_____

☐ I authorize any medical treatment for my child that may be advised or recommended by the medical providers

☐ I have personally supplied the above information and attest that is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anyone, without my written authorization. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to Health Services to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment or medical care.

Date: _____ Signature of Player: _____

Date: _____ Signature of Parent/Guardian: _____

Disclaimer: Personal information used, disclosed, secured or retained by the soccer organization will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.