



Stony Plain Football Medical Questionnaire

Name: _____ Date: _____

DOB: _____ Gender: F M Height: _____ Weight: _____

Phone #: _____ Parents Name: _____

Emergency Contact:

Name: _____ Relation: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Family Dentist: _____ Phone #: _____

Medical Conditions:

Have you ever had a concussion? Y N

Have you injured any bones or muscles that required medical attention? Please list, include left or right side. Y N

Have you ever seen a chiropractor or physical therapist for the above injuries? Y N

Have you ever been hospitalized? Y N

Do you have anemia? Y N

Do you have any allergies? Please list. Y N

Do you or any of your family members have high blood pressure? Y N

Have you ever passed out during or after exercise? Y N

Do you have any medical conditions that affect participation (diabetes, epilepsy, asthma)? Y N

Do you wear braces or any other dental appliance? Y N

Do you wear glasses, contacts, or protective eyewear? Y N

Are you presently on any medications or pills? Please list and for how long. Y N

Have you been treated for any medical conditions in the last 3 months? Please list. Y N

This medical questionnaire has been completed to the best of my knowledge, and I have not withheld any condition or injury in the past or am currently being treated for. I recognize the importance of this form to assist the team Trainer in providing prompt and accurate medical attention.

Parent or Guardian Signature (if athlete is a minor) _____ Date: _____