**SC Logo (colour).tifSC Logo (colour).tifATHLETE MEDICAL INFORMATION FORM**

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| **Athlete’s Name:** |  | | | | | | | | |
| **Birth Date (dd/mm/yy)** |  | **Age** |  | | **Male** |  | | **Female** |  |
| **Address** |  | | | | | | | | |
| **Street** | | | | | | | | |
|  | | |  | | |  | | |
| **City** | | | **Province/Territory** | | | **Postal Code** | | |
| **Athlete’s Email:** |  | | | | | | | | |
| **Healthcare Number:** |  | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Father’s Name:** |  | **Mother’s Name:** |  |
| **Address:** |  | | |
| **Street** | | |
|  |  |  |
| **City** | **Province/Territory** | **Postal Code** |
| **Father’s Phone #’s:** |  |  |  |
| **Home** | **Work** | **Cell** |
| **Mother’s Phone #’s:** |  |  |  |
| **Home** | **Work** | **Cell** |
| **Father’s Email:** |  | **Mother’s Email:** |  |

|  |  |  |
| --- | --- | --- |
| **Family Doctor:** |  |  |
| **Name** | **Phone #** |

|  |  |  |
| --- | --- | --- |
| **HEALTH HISTORY** |  | **DETAILS** |
| **Allergies** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Asthma (Respiratory)** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Blackouts/Fainting** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Chest pain** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Diabetes** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Epilepsy** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hearing Disorder** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Heart Condition** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Recurring Headaches** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Seizures** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Glasses** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Contact Lenses** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Injuries (specify)** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications (specify)** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Yes  No** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |