



Winnipeg Phoenix Football Club

Private & Confidential Athlete Medical History Form

Emergency Purposes Only

Note: This information is given voluntarily. This form was provided to Phoenix by a volunteer who was at the time a 1st responder with Winnipeg's Emergency Services. Our intent is to provide as much safety to our players as is possible. Thank you for your support and understanding. The form, when completed should be provided to the Team Manager in an envelope - the Manager will be aware of the players medical history to be the FIRST responder or a designated qualified medical professional if on hand and then if emergency services are required they will be given the form.

Athlete's Surname _____
 Athlete's Given Names _____
 Address: _____ Male _____ Female _____
 Date Of Birth (D/M/Y): ____/____/____
 Coach: _____ Date Of Last
 Manager: _____ Tetanus Booster: (D/M/Y)____/____/____
 Therapist: _____
 Mb Health No. (6 Digits): _____ Blood Group & Type: _____
 Phin (9 Digits): _____ Height: _____ Weight: _____
 Family Physician: _____ Next Of Kin: _____
 Phone (Day): _____ (Night): _____ Phone (Day): _____ (Night): _____

In Case Of Emergency Please Notify: _____
 Phone (Day): _____ (Night): _____

Outline past history or illness have you ever had or do you now have:

	Yes	No		Yes	No
Head Injury			Diabetes		
Seizures			Blood Transfusions		
Neck/Back Disorder			Hepatitis		
Fainting Spells			Thyroid Disorder		
Psychiatric Disorder			Allergies (Specify) _____		
Eye Problems			Fractures (Specify) _____		
Glasses/Contacts			Operations (Specify) _____		
Nose Bleeds			Recent Within One Year:		
Dental Problems			Infectious Disease		
Deafness/Ear Problems			Head Injury		
Asthma			Major Surgery		
Bronchitis			Traumatic Or Overuse Injury		
Heart Problems			Menstrual Problems		
Chest Pains			Kidney Problems		
Ulcers					
Bowel Problems					
Urinary Infections					

LIST ANY OTHER HEALTH PROBLEMS OT RELEVANT INFORMATION OR EXPLAIN ANY OF THE CONDITIONS MARKED YES

Medications Currently Being Used:

Prescribed: _____ Date Completed: _____
 Non-Prescribed _____ Date(S) Updated: _____

I hereby state that, to the best of my knowledge, answers to the above medical history form are accurate and complete.

Date: ____/____/____ Signature of Player _____
 Day Month Year Print Name _____
 Date: ____/____/____ Signature of Guardian _____
 Day Month Year (If athlete is under the age of 18)
 Print Name _____

NOTE: MEDICAL DATA IS CONFIDENTIAL.
 THIS FORM MUST BE KEPT IN THE CARE OF AUTHORIZED PERSONNEL ONLY AND SHOULD ACCOMPANY THE PLAYERS TO EVERY GAME AND PRACTICE. FAILURE TO COMPLY WITH THIS STATEMENT MAY BE MET WITH LEGAL ACTIONS AGAINST THE INFRINGING PARTY.