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
Head Injury		
Seizures		
Neck/Back Disorder		
Fainting Spells		
Psychiatric Disorder		
Eye Problems		
Glasses/Contacts		
Nose Bleeds		
Dental Problems		
Deafness/Ear Problems		
Asthma		
Bronchitis		
Heart Problems		
Chest Pains		
Ulcers		
Bowel Problems		
Urinary Infections		

	Yes	No
Diabetes		
Blood Transfusions		
Hepatitis		
Thyroid Disorder		
Allergies (Specify) _____		
Fractures (Specify) _____		
Operations (Specify) _____		
Recent Within One Year:		
Infectious Disease		
Head Injury		
Major Surgery		
Traumatic Or Overuse Injury		
Menstrual Problems		
Kidney Problems		

LIST ANY OTHER HEALTH PROBLEMS OT RELEVENT 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.