



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: _____

COACH: _____

MANAGER: _____

THERAPIST: _____

MB HEALTH No. (6 digits): _____

PHIN (9 digits): _____

FAMILY PHYSICIAN: _____

NEXT OF KIN: _____

IN CASE OF EMERGENCY
PLEASE NOTIFY: _____

MALE _____ FEMALE _____

DATE OF BIRTH (D/M/Y): ____/____/____

DATE OF LAST
TETANUS BOOSTER: (D/M/Y) ____/____/____

BLOOD GROUP & TYPE: _____

HEIGHT: _____

WEIGHT: _____

PHONE (DAY): _____ (NIGHT): _____

PHONE (DAY): _____ (NIGHT): _____

PHONE (DAY): _____ (NIGHT): _____

OUTLINE PAST HISTORY OR ILLNESS

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

<table border="0"> <tr><td>HEAD INJURY</td><td>YES</td><td>NO</td></tr> <tr><td>SEIZURES</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>NECK/BACK DISORDER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>FAINTING SPELLS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>PSYCHIATRIC DISORDER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>EYE PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>GLASSES/CONTACTS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>NOSE BLEEDS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>DENTAL PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>DEAFNESS/EAR PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ASTHMA</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>BRONCHITIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEART PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>CHEST PAINS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ULCERS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>BOWEL PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>URINARY INFECTIONS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	HEAD INJURY	YES	NO	SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	NECK/BACK DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DEAFNESS/EAR PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAINS	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>DIABETES</td><td>YES</td><td>NO</td></tr> <tr><td>BLOOD TRANSFUSIONS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEPATITIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>THYROID DISORDER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ALLERGIES (SPECIFY)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>FRACTURES (SPECIFY)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>OPERATIONS (SPECIFY)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="3">RECENT WITHIN ONE YEAR:</td></tr> <tr><td>INFECTIOUS DISEASE</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEAD INJURY</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>MAJOR SURGERY</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>TRAUMATIC OR OVERUSE INJURY</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>MENSTRUAL PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>KIDNEY PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	DIABETES	YES	NO	BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	FRACTURES (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	OPERATIONS (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WITHIN ONE YEAR:			INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	MAJOR SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	TRAUMATIC OR OVERUSE INJURY	<input type="checkbox"/>	<input type="checkbox"/>	MENSTRUAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
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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.