ATHLETE MEDICAL INFORMATION FORM

PLAYER INFORMATION

Date Completed: _____

Name: _____ Date of Birth: (DD/MM/YYYY) ___/___/___

Address: _____

City: _____ Postal Code: _____

Cell Phone #: ( ) - _____ Email: _____

Health Card #: _____

EMERGENCY CONTACT PERSON

Name: _____ Relationship: _____

Daytime Phone #: ( ) - _____ Evening Phone #: ( ) - _____

MEDICAL HISTORY *use the back of this form for more details*

Allergies: _____
If so please list, how serious are they?

Chronic Conditions/Previous Illnesses: _____
Chickenpox, asthma, diabetes, etc

Medications: _____
Please list any medications, including inhalers that you take?

Inoculations: _____
Date of your last tetanus booster shot, or other shots if appropriate for this tour.

Supplements: _____
Please list all ingested substances including vitamins

ANSWER ALL OF THE FOLLOWING QUESTION PERTAINING TO THE STATUS OF YOUR HEALTH ***WITHIN THE LAST YEAR*:**

1.	Has a doctor denied or restricted your participation in sport for any reason?	Yes ☑ No ☐
2.	Have you been admitted to the hospital for any reason?	Yes ● No ☐
3.	Have you had surgery?	Yes ● No ☐
	a. Have you been cleared to participate fully in sports?	Yes ● No ☐
	b. (please attach note)	
4.	Have you been advised to be on any medication on a regular basis?	Yes ● No ☐
5.	Have you had a skin infection?	Yes ● No ☐
6.	Have you had any injuries requiring you to miss more than one practice or game?	Yes ● No ☐
7.	Have you had an injury that required treatment/therapy?	Yes ● No ☐
8.	Do you currently have an incompletely healed injury?	Yes ● No ☐
9.	Have you had a concussion, or hit causing confusion, headache or memory loss?	Yes ● No ☐
	a. How many? When?	# Date
10.	Have you had a burner, stinger, neck injury?	Yes ● No ☐
11.	Have you been tested for a blood-bourne pathogen?(ie HIV, Hep B or C)	Yes ● No ☐
12.	Have you experienced coughing/wheezing with exercise?	Yes ● No ☐
13.	Have you experienced frequent or severe headaches?	Yes ● No ☐
14.	Have you got lightheaded, dizzy or felt more short of breath than expected during exercise?	Yes ● No ☐
15.	Have you experienced heat exhaustion or heat stroke?	Yes ● No ☐
16.	Has a doctor ordered testing for your heart?(ECG, EKG, ultrasound, etc)	Yes ● No ☐
17.	Have you experienced heart palpitations (heart feels like pounding or racing)	Yes ● No ☐
18.	Have you experienced unexplained weight loss/gain?	Yes ● No ☐
19.	Do you use any special equipment? (brace, pads, orthotics)	Yes ● No ☐

INJURY STATUS

Current Injuries: _____

Do you have any present injuries? Receiving treatment? What is the treatment? (use back for details)

Previous Injuries: _____

List previous injuries such as separated shoulders, fractures, dislocations, ligament reconstructions, discs, etc…

Taping Requests: _____

Example 2 ankles & 1 thumb (indicate games or practices)

Concussions/Head Injuries: _____

History from past 2 years? When and how long were you concussed for?

_____

Other Information: _____

Other *useful information not asked above, other requests for supplies, do you wear glasses, contacts, dentures, etc? Use the back for more details.*

MEDICAL INFORMATION DETAILS

CONSENT/ CERTIFICATION

I consent to the release of all information contained in, or arising from this questionnaire to the appropriate members of the support staff of Rugby Ontario and I certify that I have made a full and complete disclosure concerning any and all conditions, allergies, medications, injuries and head injury information. I have answered completely and truthfully all questions.

Printed Name (parent of playing is under 18 years of age)	Signature	Date

Note: The original version of submitted forms will be kept at the Rugby Ontario office with a copy sent with the team manager when traveling for the use of the Athletic Therapist. A player will not be able to participate in team activities until such time this form is completed and submitted to the Team Manager.