Player Medical History Form

SURNAME:_____ GIVEN NAME: _____

ADDRESS:_____ DATE OF BIRTH (MM//DD/YY): _____

_____ HEIGHT: _____WEIGHT: _____

_____ BLOOD GROUP & TYPE: _____

HEALTH CARD NO: _____ MEDICAL INSURANCE TEL NO: _____

POLICY NO: _____

FAMILY PHYSICIAN: _____ PHONE: _____

NEXT OF KIN: _____ PHONE: _____

IN CASE OF EMERGENCY
PLEASE NOTIFY:_____ PHONE: _____

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 DISRODER	___	___	HEPATITS	___	___
FAINTING SPELLS	___	___	THYROID DISORDER	___	___
PSYCHIATRIC DISORDER	___	___			
EYE PROBLEMS	___	___	ALLERGIES	___	___
GLASSES/CONTACTS	___	___	(SPECIFY)		
NOSE BLEEDS	___	___			
DENTAL PROBLEMS	___	___	FRACTURES	___	___
DEAFNESS/EARPROBLEMS	___	___	(SPECIFY)		
ASTHMA	___	___			
BRONCHITIS	___	___	OPERATIONS	___	___
CHEST PAINS	___	___	(SPECIFY)		
HEART PROBLEMS	___	___			
ULCERS	___	___	RECENT WITHIN ONE YEAR:		
BOWEL PROBLEMS	___	___	INFECTIOUS DISEASE	___	___
URINARY INFECTIONS	___	___	HEAD INJURY	___	___
KIDNEY PROBLEMS	___	___	MAJOR SURGERY	___	___
MENSTRUAL PROBLEMS	___	___	TRAUMATIC OR		
EATING DISORDERS	___	___	OVERUSE INJURY	___	___

***PLEASE LIST BELOW ANY OTHER HEALTH PROBLEMS OR RELEVANT INFORMATION OR EXPLAIN ANY OF THE CONDITIONS MAKED "YES":**

MEDICATIONS CURRENTLY USED

DATE COMPLETED: _____

PRESCRIBED:_____

NON PRESCRIBED:_____ SIGNATURE OF PARENT/GUARDIAN: _____