OLDS MINOR HOCKEY

MEDICAL FORM *To be completed by the athlete/parent/guardian*

Last Name_____ First Name_____

Address_____ City_____ Province_____

Date of Birth _____ Home Phone # (____)_____ Postal Code_____
Day Month Year

Health Care #_____ Province_____

FOR EMERGENCY NOTIFY: Name_____ Relationship_____

Address_____ Phone_____

Family Doctor's Name_____ Date of Last Physical_____
Month Year

Sport: HOCKEY

Year of Participation in Sport (circle): 1st 2nd 3rd 4th 5th 6th What position will you be playing this year?_____

Explain "Yes" answers below:	Yes	No
1. Have you ever been hospitalized?	o	o
Have you ever had surgery?	o	o
2. Are you presently taking any medications or pills?	o	o
Are you presently taking any vitamins or supplements?	o	o
3. Do you have any allergies (medicine, bees or other stinging insects)?	o	o
4. Have you ever passed out during or after exercise?	o	o
Have you ever been dizzy during or after exercise?	o	o
Have you ever had chest pain during or after exercise?	o	o
Do you tire more quickly than your friends during exercise?	o	o
Have you ever had high blood pressure?	o	o
Have you ever been told that you have a heart murmer?	o	o
Have you ever had racing of your heart or skipped heartbeats?	o	o
Has anyone in your family died of heart problems or a sudden death before age 50?	o	o
5. Do you have any skin problems (itching, rashes, acne)?	o	o
6. Have you ever had heat or muscle cramps?	o	o
Have you ever been dizzy or passed out in the heat?	o	o
7. Do you have trouble breathing or do you cough during or after activity?	o	o
8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	o	o
Do you use any dental appliances?	o	o
9. Have you had any problems with your eyes or vision?	o	o
Do you wear glasses or contacts or protective eye wear?	o	o
10. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	o	o
11. Have you had a medical problem or injury since your last evaluation?	o	o
12. Have you had any unexplained weight change?	o	o
13. When was your last tetanus shot?_____		
When was your last measles immunization?_____		
14. **Female Athletes only :** Over the past year, did your periods occur about once a month?	o	o

Explain "Yes" answers on reverse side .

HEAD INJURIES / CONCUSSIONS:

	Yes	No
15. Have you ever had a seizure?	o	o
16. Have you ever had a head injury?	o	o
Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"?	o	o

If YES, please list: Number:_____

Date(s)	Activity at the time	Length of unconsciousness (minutes)	Length of time before full return to activity

Did you have any persistent problems with:
memory YES NO dizziness YES NO headaches YES NO

NECK INJURIES / BURNERS / STINGERS:

	Yes	No
17. Have you ever had a neck injury (ie, strain, sprain, fracture, etc.)	o	o
18. Have you ever had a stinger, burner or pinched nerve?	o	o

(a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - aka. "brachial plexus stretch injury")

If YES, please list: Number:_____

Date(s) persisted?	Activity at the time	Length of time sensation/strength changes

---

19. Check any of the areas that you have **INJURED IN THE PAST** and explain the injury below:

Hand ___	Elbow ___	Neck ___	Hip ___	Shin/Calf ___
Wrist ___	Arm ___	Chest ___	Thigh ___	Ankle ___
Forearm ___	Shoulder ___	Back ___	Knee ___	Foot ___

Year of injury	Type of Injury	Side (right, left, both)	Is it still a problem? (Yes/No)

	Yes	No
20. Do you have any incompletely healed injury?	o	o

If yes, which injury?_____

I hereby certify the above information to be correct.

Athlete Signature _____ Date_____

Parent/Guardian Signature _____Date _____