

Salisbury Sabres 2014 Football Medical Form

(Side "A" – Personal Information to be filled out by **you!**)

Last Name: _____ First Name: _____ Date of Birth (dd/mm/yyyy): _____

Address: _____ City/Town: _____ Prov. _____ Postal Code: _____

Home Phone Number: (_____) _____ Email Address: _____ Date of Last Physical (dd/mm/yy): _____

Alberta Health Care Number: _____ **(Optional)**

Emergency Contact (Name): _____ Relationship (i.e. Father, Aunt): _____

Emergency Contact Phone Number: (_____) _____ Emergency Contact Address: _____

Family Doctor's Name: _____ Family Doctor's Address: _____

Family Doctor's Phone Number: (_____) _____ Family Doctor's City/Town: _____ Postal Code: _____

Answer all of the questions below by checking YES or NO

HAVE YOU EVER HAD OR DO YOU NOW HAVE

	Yes	No		Yes	No
Heat Stroke/Cramps	_____	_____	Irregular Heart Beats	_____	_____
Infectious Mononucleosis	_____	_____	High or low blood pressure	_____	_____
Scarlett or Rheumatic Fever	_____	_____	A heart murmur	_____	_____
Tonsillitis/Sinusitis	_____	_____	Ear or Hearing Trouble	_____	_____
Coughed up blood	_____	_____	Difficulties with vision	_____	_____
Asthma	_____	_____	Frequent or Severe Headaches	_____	_____
Severe tooth or gum troubles	_____	_____	Epilepsy or fits	_____	_____
Stomach Ulcers	_____	_____	Dizziness or fainting spells	_____	_____
Pneumonia or Tuberculosis	_____	_____	"Stingers" or "burners"	_____	_____
Anemia or low iron	_____	_____	A Concussion or been "knocked out"	_____	_____
Hepatitis or liver trouble	_____	_____	Loss of Memory	_____	_____
Hernia or rupture	_____	_____	Any mental illness	_____	_____
Piles or hemorrhoids	_____	_____	Motion sickness	_____	_____
Tumor or cancer	_____	_____	Smoked cigarettes	_____	_____
Used alcohol	_____	_____	Kidney stones or blood urine	_____	_____
Frequent or painful urination	_____	_____	Used non-prescription/street drugs	_____	_____
Sexually transmitted disease	_____	_____	Diabetes	_____	_____
Skin rashes	_____	_____	Allergies	_____	_____
Arthritis	_____	_____	Any other medical illness	_____	_____

	YES	NO
Have you been treated for an infectious disease in the last 12 months? If YES, which disease? _____	_____	_____
Have you ever had to stay in hospital overnight? If YES, what for? _____	_____	_____
Have you ever had any surgery? If YES, what for? _____	_____	_____
Have you ever had any broken bones? If YES, which bones? _____	_____	_____
Do you wear contact lenses or glasses? If YES, which do you play sports with? _____	_____	_____
Do you have an eye condition that requires a tinted visor while playing football? If YES, please attach note from doctor. _____	_____	_____
Have you seen a physiotherapist and/or chiropractor? If YES, what for? _____	_____	_____
Do you have any pins, plates or screws in your body from any bone or joint surgery? If YES, where? _____	_____	_____
Do you wear any dental appliances such as braces or a plate? _____	_____	_____

FAMILY HISTORY: Please circle any illnesses that have affected family members past or present.

Diabetes, Allergies, Arthritis, Neurological Disorders, Gout, Heart Disease, High Blood Pressure, High Cholesterol, Bleeding Problems, Kidney Disease, Mental Illness, Sickle Cell Anemia

Has anyone in your family died suddenly before the age of 40? _____ YES _____ No

	YES	NO
ARE YOU TAKING ANY MEDICATIONS? If YES, please list. _____	_____	_____
ARE YOU TAKING ANY SUPPLEMENTS? If YES, please list. _____	_____	_____
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? If YES, please list. _____	_____	_____
DO YOU HAVE ANY OTHER ALLERGIES (i.e. bees)? If YES, please list. _____	_____	_____

WHEN WERE YOUR IMMUNIZATIONS LAST UPDATED (Including Tetanus) (dd/mm/yyyy) _____

CHECK ANY OF THE AREAS THAT YOU HAVE INJURED IN THE PAST AND EXPLAIN THE INJURY BELOW:

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

Salisbury Sabres 2014 Football Medical Form

(Side "B" – Physical Examination to be filled out by a *doctor!*)

Examining Physician: _____

Phone Number(_____) _____

Examining Physician's Signature: _____

Date: _____

Player Examination

Height (ft./in.) _____

Weight (lbs.) _____

BP: ____/____

Resting Pulse: _____

EENT: _____

TEETH: _____

CHEST: _____

CARDIOVASCULAR (pulses, heart sound, and murmurs): _____

ABDOMEN (organomegaly, hernias, genitals): _____

CNS: _____ DTR's: _____

SKIN: _____

MUSCULOSKELETAL (Please note any evidence of prior injury, instability or loss of flexibility):

HAND/WRIST: _____

ELBOW: _____

SHOULDER: _____

NECK/BACK: _____

HIP/PELVIS: _____

KNEE: _____

ANKLE/FEET: _____

ADDITIONAL COMMENTS / ABNORMAL FINDINGS: _____

LABORATORY (if indicated): CBC: _____

Urine: _____

Others as indicated: _____

CLEARANCE FOR PARTICIPATION:

RECOMMENDATIONS PRIOR TO PARTICIPATION:

No Restrictions (contact/collision) _____

Limited Contact/impact _____

Non-Contact: Strenuous _____

Moderate _____

Non-Strenuous _____

Needs further consultation/tests _____

Not fit _____

INFORMATION RELEASE CONSENT:

I the undersigned (or my parent/guardian) consent to the release of the information contained in this medical report to Football Alberta or contracted agents for the purposes of my participation in programs offered within the sport of football.

PLAYER SIGNATURE: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

(if player is under the age of 18)