|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name |       | First Name |       | Date of Birth |       |
| Address |       |
| Home Phone  |       | Cell Phone  |       | Email  |       |
| Emergency Contact  |       | Relationship (mother, father, aunt) |       |
| Emergency Contact Cell Phone |       |
| Physician  |       | Physician Address |       |
| Physician Phone Number  |       | Date of Last Physical |       |
| Alberta Health Care Number (optional) |       |

**Please “check” if the player is currently or has ever experienced any of the following:**

|  |  |  |
| --- | --- | --- |
| Heat Stroke |[ ]  Irregular Heart Beat |[ ]  Frequent or Painful Urination  |[ ]
| Infectious Mononucleosis  |[ ]  High or Low Blood Pressure  |[ ]  Sexually Transmitted Infections  |[ ]
| Scarlett or Rheumatic Fever |[ ]  Heart Murmur  |[ ]  Alcohol Use |[ ]
| Tonsillitis/ Sinusitis  |[ ]  Ear or Hearing Trouble  |[ ]  Non-prescription/ street drug use |[ ]
| Cough up Blood |[ ]  Difficulty with Vision  |[ ]  Tobacco Use |[ ]
| Asthma |[ ]  Frequent or Severe Headaches |[ ]  Tumor or Cancer |[ ]
| Sever Tooth or Gum Troubles |[ ]  Epilepsy of Fits  |[ ]  Kidney stones or blood in urine |[ ]
| Stomach Ulcers |[ ]  Dizziness or Fainting Spells  |[ ]  Diabetes |[ ]
| Pneumonia or Tuberculosis  |[ ]  “Stingers” or “Burners” |[ ]  Allergies |[ ]
| Anemia or Low Iron  |[ ]  Concussion or been “knocked out” |[ ]  Skin Rashes  |[ ]
| Hepatitis or Liver Trouble  |[ ]  Loss of Memory |[ ]  Arthritis |[ ]
| Hernia or Rupture |[ ]  Any Mental Health Concerns  |[ ]  Any other medical illness |[ ]
| Piles or Hemorrhoids  |[ ]  Motion Sickness  |[ ]   |  |

**Please check all that apply and provide details:**

|  |
| --- |
| Have you ever been treated for an infectious disease in the last 12 months? |[ ]
| If YES what disease:      |
| Have you ever had any surgery? |[ ]
| If YES, for what:      |
| Have you ever had any broken bones  |[ ]
| If YES, which one(s):      |
| Do you wear contacts of glasses? |[ ]
| If YES, which do you wear to play sports with:      |
| Do you have an eye condition which requires you to wear a tinted visor while playing football? Medical note required |[ ]
| Have you seen a physiotherapist or a chiropractor? |[ ]
| If YES, for what:      |
| Do you have any pins, plates or screws in your body from and bone or joint surgery? |[ ]
| If YES, where:      |
| Do you wear any dental appliances such as braces or a plate? |[ ]

**Family History: Please check any illnesses that have affected family members past or present:**

|  |  |  |  |
| --- | --- | --- | --- |
| Diabetes |[ ]  Allergies |[ ]  Arthritis  |[ ]  Kidney Disease |[ ]
| Neurological Disorders |[ ]  Mental Health Concerns |[ ]  Sickle Cell Anemia |[ ]  Gout |[ ]
| High Blood Pressure  |[ ]  High Cholesterol  |[ ]  Bleeding Problems  |[ ]  Heart Disease |[ ]
| Has any one in your family dies suddenly before the age or 40? |[ ]   |

|  |
| --- |
| Please list any medications you are taking:      |
| List any allergies (i.e. medications, bees):      |
| When were your immunizations last updated (including tetanus)?      |
| Provide details of any prior injuries (including location such as hand, elbow, neck, hip, ankle, shin/calf, wrist, knee, foot, arm, chest, thigh, shoulder, back):       |