|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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): |