

Salisbury Sabres Football Medical Form

Part A - Personal Information to be filled out by parent/legal guardian PRIOR to Spring Camp

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

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 or 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 | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Neurological Disorders | <input type="checkbox"/> | Mental Health Concerns | <input type="checkbox"/> | Sickle Cell Anemia | <input type="checkbox"/> | Gout | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
- 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):