



## ATHLETE MEDICAL INFORMATION FORM 2020

### PLAYER INFORMATION

Date Completed: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: (DD/MM/YYYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Cell Phone #: ( ) - \_\_\_\_\_ Email: \_\_\_\_\_

Health Card #: \_\_\_\_\_

### EMERGENCY CONTACT PERSON

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone #: ( ) - \_\_\_\_\_ Evening Phone #: ( ) - \_\_\_\_\_

### MEDICAL HISTORY *use the back of this form for more details*

**Allergies:** \_\_\_\_\_  
*If so please list, how serious are they?*

**Chronic Conditions/Previous Illnesses:** \_\_\_\_\_  
*Chickenpox, asthma, diabetes, etc*

**Medications:** \_\_\_\_\_  
*Please list any medications, including inhalers that you take?*

**Inoculations:** \_\_\_\_\_  
*Date of your last tetanus booster shot, or other shots if appropriate for this tour.*

**Supplements:** \_\_\_\_\_  
*Please list all ingested substances including vitamins*

**ANSWER ALL OF THE FOLLOWING QUESTION PERTAINING TO THE STATUS OF YOUR HEALTH WITHIN THE LAST YEAR:**

1. Has a doctor denied or restricted your participation in sport for any reason?	Yes	No
2. Have you been admitted to the hospital for any reason?	Yes	No
3. Have you had surgery?	Yes	No
a. Have you been cleared to participate fully in sports?	Yes	No
b. (please attach note)		
4. Have you been advised to be on any medication on a regular basis?	Yes	No
5. Have you had a skin infection?	Yes	No
6. Have you had any injuries requiring you to miss more than one practice or game?	Yes	No
7. Have you had an injury that required treatment/therapy?	Yes	No
8. Do you currently have an incompletely healed injury?	Yes	No
9. Have you had a concussion, or hit causing confusion, headache or memory loss?	Yes	No
a. How many? When?	#	Date
10. Have you had a burn, stinger, neck injury?	Yes	No
11. Have you been tested for a blood-borne pathogen?(ie HIV, Hep B or C)	Yes	No
12. Have you experienced coughing/wheezing with exercise?	Yes	No
13. Have you experienced frequent or severe headaches?	Yes	No
14. Have you got lightheaded, dizzy or felt more short of breath than expected during exercise?	Yes	No
15. Have you experienced heat exhaustion or heat stroke?	Yes	No
16. Has a doctor ordered testing for your heart?(ECG, EKG, ultrasound, etc)	Yes	No
17. Have you experienced heart palpitations (heart feels like pounding or racing)	Yes	No
18. Have you experienced unexplained weight loss/gain?	Yes	No
19. Do you use any special equipment? (brace, pads, orthotics)	Yes	No

**INJURY STATUS**

**Current Injuries:** \_\_\_\_\_

*Do you have any present injuries? Receiving treatment? What is the treatment? (use back for details)*

**Previous Injuries:** \_\_\_\_\_

*List previous injuries such as separated shoulders, fractures, dislocations, ligament reconstructions, discs, etc...*

**Taping Requests:** \_\_\_\_\_

*Example 2 ankles & 1 thumb (indicate games or practices)*

**Concussions/Head Injuries:** \_\_\_\_\_

*History from past 2 years? When and how long were you concussed for?*

**Other Information:** \_\_\_\_\_

*Other useful information not asked above, other requests for supplies, do you wear glasses, contacts, dentures, etc? Use the back for more details.*

**MEDICAL INFORMATION DETAILS**

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**CONSENT/ CERTIFICATION**

I consent to the release of all information contained in, or arising from this questionnaire to the appropriate members of the support staff of Rugby Ontario and I certify that I have made a full and complete disclosure concerning any and all conditions, allergies, medications, injuries and head injury information. I have answered completely and truthfully all questions.

Printed Name (parent of playing is under 18 years of age)	Signature	Date
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*Note: The original version of submitted forms will be kept at the Rugby Ontario office with a copy sent with the team manager when traveling for the use of the Athletic Therapist. A player will not be able to participate in team activities until such time this form is completed and submitted to the Team Manager.*