PRE-COMPETITION MEDICAL SCREENING – ATHLETE INFORMATION

Style: (please circle) **FS:** ☐ **GR :** ☐ **FW:** ☐ **Age Division: (please circle)** **SR:** ☐ **JR:** ☐ **U19:** ☐ **U17:** ☐

Name: ______________________________ **Date of Birth (dd/mm/yyyy):** ____________________

Address: ____

City/Town: ____________________________ **Province:** __________ **Postal Code:** ______________

Home Phone: ____________________________

Emergency Contact: ____

Relation: ______________________________ **Phone:** ______________________________

MEDICAL INFORMATION

This information will be kept in confidence and will ONLY be released if required to deal with a medical situation concerning the health and well-being of the athlete.

Medical Card Number: ______________________________

Taking Any Medication? **YES:** ☐ **NO:** ☐

If YES, please specify: ____

Allergies (eg. Bee stings, prescription or non-prescription medications, food allergies, etc.): **YES:** ☐ **NO:** ☐

If YES, please specify: ____

History of any previous head or neck injuries and/or concussions? **YES:** ☐ **NO:** ☐

If YES, please specify: ____

Medical conditions (eg. Heart condition, epilepsy): **YES:** ☐ **NO:** ☐

If YES, please specify: ____

Recent surgeries within the last 6 months: **YES:** ☐ **NO:** ☐

If YES, please specify: ____

Do you have a known injury or medical condition that will need medical support (athletic/physiotherapy, massage therapy, chiropractic treatment, or physician) during the current competition? **YES:** ☐ **NO:** ☐

If YES, please specify: ____

______________________________________ ____________________

Signature of Athlete (**REQUIRED**) Date

______________________________________ ____________________

Signature of Parent/Guardian (**REQUIRED** if athlete is under 18 years of age) Date