MEDICAL FORM FOR CALGARY NORTHSTARS HOCKEY ASSOCIATION

Last Name ________________________________ First Name __________________________

Address ________________________________ City __________________ Province _______

Date of Birth _______________ Home Phone # (_____)________ Postal Code ____________
DD/MM/YY

Health Care # ________________________________ Province _________________________

FOR EMERGENCY NOTIFY: Name ______________________ Relationship _______________

Address ____ Phone __________________________

Family Doctor's Name ________________________ Date of Last Physical ________________
MM/YY

Sport: ____

Year of Participation in Hockey (circle one): 1st 2nd 3rd 4th 5th 6th

What position will you be playing this year? ________

Explain "Yes" answers below:	Yes	No
1. Have you ever been hospitalized?	o	o
Have you ever had surgery?	o	o
2. Are you presently taking any medications or pills?	o	o
Are you presently taking any vitamins or supplements?	o	o
3. Do you have any allergies (medicine, bees or other stinging insects)?	o	o
4. Have you ever passed out during or after exercise?	o	o
Have you ever been dizzy during or after exercise?	o	o
Have you ever had chest pain during or after exercise?	o	o
Do you tire more quickly than your friends during exercise?	o	o
Have you ever had high blood pressure?	o	o
Have you ever been told that you have a heart murmur?	o	o
Have you ever had racing of your heart or skipped heartbeats?	o	o
Has anyone in your family died of heart problems or a sudden	o	o
death before age 50?	o	o
5. Do you have any skin problems (itching, rashes, acne)?	o	o

	Yes	No
6. Have you ever had heat or muscle cramps?	o	o
Have you ever been dizzy or passed out in the heat?	o	o
7. Do you have trouble breathing or do you cough during or after activity?	o	o
8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	o	o
Do you use any dental appliances?	o	o
9. Have you had any problems with your eyes or vision?	o	o
Do you wear glasses, contact lenses or protective eye wear?	o	o
10. Have you had any other medical problems (infectious mononucleosis? diabetes, etc.)?	o	o
11. Have you had a medical problem or injury since your last evaluation?	o	o
12. Have you had any unexplained weight change?	o	o

13. When was your last tetanus shot? ______________

When was your last measles immunization? ______

Explain "Yes" answers here.

____

____

____

____

____

____

HEAD INJURIES / CONCUSSIONS:

	Yes	No
15. Have you ever had a seizure?	o	o
16. Have you ever had a head injury?	o	o
Have you ever had a concussion or been "knocked out", had your "bell rung",or been "dinged"?	o	o

If YES, please list: Number of times:

Date(s) Activity at the time Length of unconsciousness (minutes)

Length of time before full return to activity

Did you have any persistent problems with?

Memory YES NO Dizziness YES NO Headaches YES NO

NECK INJURIES / BURNERS / STINGERS*: Yes No

17. Have you ever had a neck injury (i.e. strain, sprain, fracture, etc.)........................ o o
18. Have you ever had a stinger, burner or pinched nerve? .... o o

(*Refers to a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - AKA "Brachial plexus stretch injury")

If YES, please list number of stingers experienced:

Date(s) Activity at the time

Length of time sensation/strength changes persisted:

19. Check any of the areas that you have **INJURED IN THE PAST** and explain the injury in the space provided below:

Hand__________Elbow_________Neck__________Hip___________Shin ____
Wrist__________Arm___________Chest_________Thigh_________Ankle____
Forearm_______Shoulder_______Back__________Knee__________Foot ____

Year of injury Type of Injury Side (right, left, both) Is it still a problem? (Yes/No)

____
____
____
____

Yes No

20. Do you have any incompletely healed injury?... o o

If yes, which injury?____

I hereby certify the above information to be correct.

Athlete Signature ____________________________________ Date ______________

Parent/Guardian Signature ______________________________ Date ______________