



MEDICAL FORM TEMPLATE FOR MHA'S

Last Name _____ First Name _____

Address _____ City _____ Province _____

Date of Birth _____ Home Phone # () _____ Postal Code _____

Alberta Health Care # _____ (optional)

FOR EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Phone _____

Any medical conditions or Allergies the team should know about:

Explain "Yes" answers below:

Yes No

1. Are you presently taking any medications or pills? 0 0
Are you presently taking any vitamins or supplements? 0 0
2. Have you ever passed out during or after exercise? 0 0
Have you ever been dizzy during or after exercise?..... 0 0
Have you ever had chest pain during or after exercise?..... 0 0
3. Do you have trouble breathing or do you cough during or after activity? 0 0
4. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?..... 0 0
5. Do you use any dental appliances? 0 0
6. Have you had any problems with your eyes or vision? 0 0
Do you wear glasses or contacts or protective eye wear?..... 0 0

Explain "Yes" answers

HEAD INJURIES / CONCUSSIONS:

Yes No

7. Have you ever had a seizure? 0 0
8. Have you ever had a head injury? 0 0
9. Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"?..... 0 0

If YES, please list: Number: _____

Date(s)	Activity at the time	Length of unconsciousness (minutes)	Length of time before full return to activity
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I hereby certify the above information to be correct.

Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____