PRE-COMPETITION MEDICAL SCREENING – ATHLETE INFORMATION

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

Name: _____ **Date of Birth (mm/dd/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