## Stelly's Athletics Medical Info Form

- ✓ THIS FORM MUST BE COMPLETED AND RETURNED.
- ✓ INFORMATION IS COMPLETELY CONFIDENTIAL ALTHOUGH THE COACH MAY HAVE TO SHARE THIS INFO WITH A HEALTH CARE PROVIDER.
- ✓ PLEASE PRINT IN INK.

- ✓ THE FIRST AID PERSON/COACH WILL CARRY THIS FORM ON ALL TRIPS
- ✓ PLEASE FILL OUT CONTACT NUMBERS CAREFULLY.
- $\checkmark~$  YOU MUST ANSWER ALL OF THE AREAS (USE N/A DO NOT LEAVE BLANK).
- ✓ <u>MUST</u> BE HANDED PRIOR TO COMPETING.

STUDI	ENT'S NAME:	CA	CARE CARD NUMBER:							
DATE OF BIRTH		(MONTH/DA	AY/YEAR)							
STREET ADDRESS										
CITY		PROVINCE	POSTAL CODE							
	TACT INFORMATION and Number of person to call in	case of an emerg	gency:							
1st ch	oice name:	Relationsh	_ Relationship							
Work phone:		Best time?	Best time?							
2nd choice name:										
Home phone:										
Physician's Name:										
MEDICAL HISTORY PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL/PHYSICAL CONDITION AND GIVE DETAILS BELOW										
	Angina Arthritis									
_	Asthma		Including the above please list any/all medical							
	Breathing Problems		conditions (hepatitis, kidney ailment) or physical							
	Bursitis		conditions (seizure disorders, bad back, joint							
	Concussion /Previous Head Inj	ury	problems, etc.) that may affect your ability to							
	Chronic Joint Injuries		participate in this program. For emergency							
	Diabetes Hearing Deficiency		purposes, please describe all past and present							
	Heart Condition		problems, how they affect you, what are the							
	High Blood Pressure		symptoms of onset, and what brings them on:							
_	Inner Ear or Balance Problem									
	Infectious Disease									
	Migraine Headaches									
	Poor Eyesight									
	Recurring muscle injuries									
	Rheumatic fever									
	Tendonitis									

Ulcers

<b>MEDICATION</b>							
					tion, and their deta		
Medication	Dosage	Frequency	Reaso	on Taken	Side Effects	Expiry Date	
						+	
•		cation with you	, please:				
	hat it has not expired	d! . rproof and sun proof co	ntainara		rint the name of the drug on		ntainar
Pack it in	i two separate water	rproof and sun proof co	mamers	• L	ist detailed dosage and frequ	ency instructions on each co	mamer
ALIEDCIE	C/DIETADV	RESTRICTION	ONG				
		allergies (or di		strictions)?	Yes No		
1. Do you nav	ve any knowi	i allergies (or di	ietary res	strictions)?	ies no		
	1 1 1		`	37	NT		
•		llergic reaction?		Ye			
•		vere (Anaphylac					
_		, please describ	e what c	auses the rea	ction, what happen	is, and any medicat	tion you
take or carry:							
<b>TETANUS I</b>	NOCULATI	ION HISTORY	<u>Y</u>				
Tetanus booster	s are good for to	en years. Typically	these are	administered t	o grade 9 students.		
What was the da	ate of your last	Tetanus inoculation	n or booste	er? Month	Year		
<b>MEDICAL I</b>	PROCEDUR	<b>E HISTORY</b>					
Have you had:		hetic (put to sleep)	Yes	No			
	Local Anesther	tic (freezing)	Yes	No			
	0						
Any Operations	?						
						<del></del>	
CICAL DID	TO C						
<b>SIGNATUR</b>							
					ully, to the best of		
					orm the coach of a	ny	
medical cond	ditions that n	nay have arise	n after f	illing out th	is form.		
G: 1.1		C	2005				
Signed the	day	of	_, 2005				
Participant Signat	uro		Doront o	or Guardian Sign	ntura		
i articipant Signat	uic		rarent C	n Guaruian Sign	ature		
School use only	7						
-					Physician Call r	equired	
Initials:					Parent Call requ	•	
				_		- <del></del>	
1000							