RUGBY ALBERTA
PLAYER MEDICAL INFORMATION

DATE: ______________________

PERSONAL INFORMATION

Name		Date of Birth	
Address		City	
Province		Postal Code	
Phone		Health Card # (and Province if applicable)	

EMERGENCY CONTACT PERSON

Name		Relation	
Day Phone #		Night Phone #	

EXTENDED HEALTH PLAN COVERAGE (PARENTS WILL HAVE THIS INFORMATION, AS IT'S LIKELY THROUGH THEIR WORK)

Company		Policy Number	

MEDICAL HISTORY

Allergies	
(do you have any, what are they how serious are they?)	
Conditions	
(asthma, diabetes, etc.)	
Medications	
(are you on any medication, what is the medication?)	
Concussions	
(have you ever had one, when, how serious?)	
Inoculations	
(date of your last tetanus booster shot or other shots if appropriate)	

INJURY STATUS

Current Injuries	
(do you have any, what are they how serious are they?)	
Previous Injuries	
(concussions, dislocations, fractures, surgeries, etc.)	
Taping Requests	
(Indicate if this is for games and/or practices)	
Have you had mono in the past year?	
Do you wear contacts, glasses, dentures, partial teeth?	
Other medical information we should know?	

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONS WITH AS MUCH ACCURACY AS POSSIBLE:

Family History: Please identify any health problems that have occurred in your immediate family. Circle the appropriate response.

Y N Has anyone in your family (under age 50) died suddenly?
Y N High blood pressure
Y N Heart trouble
Y N Cancer or tumour
Y N Migraine or headaches
Y N Emotional problems
Y N Allergies/asthma
Y N Anaemia
Y N Diabetes
Y N Epilepsy
Y N Kidney/bladder disorder
Y N Stomach disorder
Y N Genetic disorder

Specify:

Do you at the present time experience:

Y N Difficulties with your eyes or vision?
Y N Difficulties with your nose or throat?
Y N Problems with hearing?
Y N Headaches, dizziness, weakness, fainting, any problems with co-ordination or balance?
Y N Numbness in any part of the body?
Y N Any tendency to shake or tremble?
Y N Cough, shortness of breath, chest pain or palpitations?
Y N Poor appetite, vomiting, abdominal pain, abnormal bowel habits?
Y N Any symptoms referable to the muscles, bones or joints, i.e., stiffness, swelling, pain?
Y N Any problems with the skin such as sores, rashes, itchy or burning sensations, etc.?
Y N Other symptoms?

Have you ever had, or been told you had, or consulted a physician for:

Y N Diabetes, goitre or any other disease of the glands (eg., mononucleosis)?
If yes, when:

Y N Epilepsy?

Y N Nervous disorder or any disease of the brain or nervous system?

Y N Heart trouble or rheumatic fever?

Y N Varicose veins, phlebitis, hemorrhoids?

Y N Any tendency of the blood toward easy bruising or bleeding?

Y N Tuberculosis, asthma or any lung disease or respiratory disorder?

Y N Ulcers or any disease of the stomach, intestines, liver or gallbladder?

Y N Sugar, albumin or blood in the urine or any disease of the kidneys?

Y N Arthritis, rheumatism or any injury or disease of the bones, peripheral joints, back or spine?

Y N Hernia or any disease of the muscles or skin?

Y N Cancer, tumour or growth of any kind?

Y N Have you ever had a head injury causing severe dizziness, loss of memory, vomiting, unconsciousness or requiring medical attention or hospitalization?
If yes, when:

Heat Disorder:

Y N Have you ever had trouble with dehydration?

Y N Have you ever had heat stroke?

Y N If yes, were you hospitalized?

Y N Other heat disorder? (specify at the end)

Y N Has your weight changed in the last year? How much?

Y N Any explanation for this change? Specify:

Y N Are you more thirsty than usual lately?

Drug, Food Supplements and Miscellaneous Agents:

Y N Are you taking any medications at present? Specify:

Y N Are you taking any vitamins at present? Specify:

Y N Are you taking any stimulants? Specify?

Y N Are you taking any anabolic agents? Specify:

Y N Are you taking any sleeping pills? Specify:

Y N Are you taking any other prescription drugs? Specify:

Y N Are you taking any non-prescription drugs not listed above?
Specify:

Y N Do you smoke? If yes, how much a day?

Y N Do you drink alcoholic beverages? If yes, how much per week?

Y N Have you ever been advised for medical reasons not to participate in sport for any period?

Y N Do you wear glasses for sports?

Y N Do you wear contact lenses for sports? If yes, are they soft____ or hard____?

THE APPROPRIATE SIGNATURE SECTION
MUST BE
COMPLETED FOR EACH ATHLETE

I confirm that I am:

__ Under the age of 18
__ Of the full age of 18 years

I have read understood and agree to the contents of this form in its entirety.

______________________________________ ___________________________________
Signature of Athlete **Date**

____
Print Athlete Name

______________________________________ ___________________________________
Signature of Witness **Date**

_____________________________________ ___________________________________
Print name **Print Name**

FOR EACH PARTICIPANT UNDER THE AGE OF 18, HIS PARENT OR GUARDIAN MUST COMPLETE THE FOLLOWING:

I as the parent guardian of the player named herein, hereby declare the contents of this form is accurate to the best of our knowledge.

______________________________________ ___________________________________
Signature of Parent/Guardian **Date**

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Print Name of Parent/Guardian

ALL INFORMATION GATHERED IS PROTECTED UNDER THE FOIPP AND WILL BE KEPT CONFIDENTIAL. INFORMATION WILL BE USED ONLY I THE EVENT OF A MEDICAL EMERGENCY.