PLAYER MEDICAL FORM

PLAYER HEALTH HISTORY

Date: D D M M Y Y Y Y

First Name

Last Name

Date of Birth D D M M Y Y Y Y

Family Doctor

Health Card # (including Version Code):

Present Address (Residence)

City

Province

Zip Code

Country

Phone

E-mail

Fax

Emergency contact

Emergency contact Phone #

Please list any medications or supplements you are currently taking:

Please list any prior injuries:

Please list any prior concussions, including the year they occurred:

Please list any prior surgeries:

Please identify any orthopedic devices (pins, plates, rods, artificial joints or limbs):

Are you currently under the care of another healthcare professional? (Sports MD, chiropractor, physiotherapist, specialist, etc?)

Please list any other relevant medical history (asthma, etc.):