ATHLETE MEDICAL INFORMATION FORM

Athlete's Name:							
Birth Date (dd/mm/yy)		**Age**		**Male** ☐		**Female** ☐	
Address	Street						
	City	Province/Territory	Postal Code				
Athlete's Email:							
Healthcare Number:							

Father's Name:		**Mother's Name:**	
Address:	Street		
	City	Province/Territory	Postal Code
Father's Phone #'s:	Home	Work	Cell
Mother's Phone #'s:	Home	Work	Cell
Father's Email:		**Mother's Email:**	

Family Doctor:	Name	Phone #

HEALTH HISTORY		DETAILS
Allergies	**Yes** ☐ **No** ☐	_____
Asthma (Respiratory)	**Yes** ☐ **No** ☐	_____
Blackouts/Fainting	**Yes** ☐ **No** ☐	_____
Chest pain	**Yes** ☐ **No** ☐	_____
Diabetes	**Yes** ☐ **No** ☐	_____
Epilepsy	**Yes** ☐ **No** ☐	_____
Hearing Disorder	**Yes** ☐ **No** ☐	_____
Heart Condition	**Yes** ☐ **No** ☐	_____
Recurring Headaches	**Yes** ☐ **No** ☐	_____
Seizures	**Yes** ☐ **No** ☐	_____
Glasses	**Yes** ☐ **No** ☐	_____
Contact Lenses	**Yes** ☐ **No** ☐	_____
Injuries (specify)	**Yes** ☐ **No** ☐	_____
Medications (specify)	**Yes** ☐ **No** ☐	_____
Other: _____	**Yes** ☐ **No** ☐	_____
Other: _____	**Yes** ☐ **No** ☐	_____