PARKLAND FOOTBALL MEDICAL FORM

(Side "A" – Personal Information to be filled out by you!)

Last Name:_____ First Name:_____ Date of Birth:_____(dd/mm/yy)

Address:_____ City/Town:_____ Prov._____ Postal Code:_____

Home Phone Number: ( )_____ Email Address:_____ Date of Last Physical: _____(dd/mm/yy)

Alberta Heath Care Number:_____

Emergency Contact (Name):_____ Relationship (i.e. Father, Aunt):_____

Emergency Contact Phone Number: ( )_____ Emergency Contact Address:_____

Family Doctor's Name:_____ Family Doctor's Address:_____

Family Doctor's Phone Number: ( )_____ Family Doctor's City/Town:_____ Postal Code:_____

HAVE YOU EVER HAD OR DO YOU NOW HAVE

Answer all of the questions below by checking YES or NO

	Yes	No
Heat Stroke/Cramps	○	○
Infectious Mononucleosis	○	○
Scarlett or Rheumatic Fever	○	○
Tonsillitis/Sinusitis	○	○
Coughed up blood	○	○
Asthma	○	○
Severe tooth or gum troubles	○	○
Stomach Ulcers	○	○
Pneumonia or Tuberculosis	○	○
Anemia or low iron	○	○
Hepatitis or liver trouble	○	○
Hernia or rupture	○	○
Piles or haemorrhoids	○	○
Tumour or cancer	○	○
Used alcohol	○	○
Frequent or painful urination	○	○
Sexually transmitted disease	○	○
Skin rashes	○	○
Arthritis	○	○

HAVE YOU EVER HAD OR DO YOU NOW HAVE

Answer all of the questions below by checking YES or NO

	Yes	No
Irregular Heart Beats	○	○
High or low blood pressure	○	○
A heart murmer	○	○
Ear or Hearing Trouble	○	○
Difficulties with vision	○	○
Frequent or Severe Headaches	○	○
Epilepsy or fits	○	○
Dizziness or fainting spells	○	○
"Stingers" or "burners"	○	○
A Concussion or been "knocked out"	○	○
Loss of Memory	○	○
Any mental illness	○	○
Motion sickness	○	○
Smoked cigarettes	○	○
Kidney stones or blood urinel	○	○
Used non-prescription/street drugs	○	○
Diabetes	○	○
Allergies	○	○
Any other medical illness	○	○

	Yes	No
Have you been treated for an infectious disease in the last 12 months? If YES, which disease?_____	○	○
Have you ever had to stay in hospital overnight? If YES, what for? _____	○	○
Have you ever had any surgery? If YES, what for? _____	○	○
Have you ever had any broken bones? If YES, which bones? _____	○	○
Do you wear contact lenses or glasses? If YES, which do you play sports with? _____	○	○
Do you have an eye condition that requires a tinted visor while playing football? If YES, please attach note from doctor. _____	○	○
Have you seen a physiotherapist and/or chiropractor? If YES, what for? _____	○	○
Do you have any pins, plates or screws in your body from any bone or joint surgery? If YES, where?_____	○	○
Do you wear any dental appliances such as braces or a plate?	○	○

FAMILY HISTORY: Please circle any illnesses that have affected family members past or present.

Diabetes, Allergies, Arthritis, Neurological Disorders, Gout, Heart Disease, High Blood Pressure, High Cholesterol, Bleeding Problems, Kidney Disease, Mental Illness, Sickle Cell Anemia

	Yes	No
Has anyone in your family died suddenly before the age of 40?	○	○

	Yes	No
ARE YOU TAKING ANY MEDICATIONS? If YES, please list._____	○	○
ARE YOU TAKING ANY SUPPLIMENTS? If YES, please list._____	○	○
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? If YES, please list._____	○	○
DO YOU HAVE ANY OTHER ALLERGIES (i.e. bees)? If YES, please list_____	○	○

WHEN WERE YOUR IMMUNIZATIONS LAST UPDATED (Including Tetanus) (dd/mm/yy) _____

CHECK ANY OF THE AREAS THAT YOU HAVE INJURED IN THE PAST AND EXPLAIN THE INJURY BELOW:

Hand ____	Elbow ____	Neck____	Hip____	Shin/calf____	Wrist____	Knee____	Foot____
Arm ____	Chest____	Thigh____	Ankle____	Forearm____	Shoulder____	Back____	Neck____

_____

_____

_____

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Parkland Football Medical Form

(Side "B" – Physical Examination to be filled out by a Physician)

Examining Physician:_____ Phone Number(____)_____

Examining Physician's Signature:_____ Date:_____

Player Examination

Height (ft./in.)_____ Weight (lbs.)_____ BP:_____/_____ Resting Pulse:_____

EENT:_____TEETH:_____

CHEST:_____

CARDIOVASCULAR (pulses, heart sounds, murmurs)_____

ABDOMEN (organomegaly, hernias, genitals):_____

CNS:_____DTR's:_____

SKIN:_____

MUSCULOSKELETAL (Please note any evidence of prior injury, instability or loss of flexibility):

HAND/WRIST: _____

ELBOW:_____

SHOULDER:_____

NECK/BACK:_____

HIP/PELVIS:_____

KNEE:_____

ANKLE/FEET:_____

ADDITIONAL COMMENTS / ABNORMAL FINDINGS:

_____

_____

LABORATORY(ifindicated):CBC:_____Urine:_____

Others as indicated:_____

CLEARANCE FOR PARTICIPATION:

No Restrictions (contact/collision) ____
Limited Contact/impact ____
Non-Contact: Strenuous ____
Moderate ____
Non-Strenuous ____
Needs further consultation/tests ____
Not fit ____

RECOMMENDATIONS PRIOR TO PARTICIPATION:

_____

_____

_____

_____

INFORMATION RELEASE CONSENT:

I the undersigned (or my parent/guardian) consent to the release of the information contained in this medical report to Parkland Football Assc. or contracted agents for the purposes of my participation in programs offered within the sport of football.

PLAYER SIGNATURE:_____ **DATE**:_____

PARENT/GUARDIAN SIGNATURE:_____ **DATE**:_____

(if player is under the age of 18)

Return Completed (both sides) Form to: Parkland Football Association, Box 3624, 360 Saskatchewan Drive, Spruce Grove, AB., T7X 3B2

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