

ATHLETE INFORMATION & MEDICAL HISTORY FORM

Date completed (MM/DD/YY): ____ / ____ / ____ Last reviewed: 1 yr 2 yrs 3 yrs

1. Personal Information SOO Registration Number (if known): _____

First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt / Unit # _____

City _____ Province **ONTARIO** Postal Code _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

e-mail (athlete) _____

____ / ____ / ____

Gender: Male Female

Date of Birth (MM/DD/YY) *optional

OHIP Number *This information is provided voluntarily and not required for the completion of this form

2. Living Arrangements

Independent Family Group Home Other _____

3. Emergency Contact(s)

1. Name _____ Relationship to Athlete _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

2. Name _____ Relationship to Athlete _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

4. Medical Contact(s)

Family Doctor (please print name) _____

Phone Number (____) _____

5. Medical History

Please check Yes (Y) or No (N) for all areas

If yes, please specify in the boxes below

Y N

- Food Allergies
- Sting/Bite Allergies
- Medicine Allergies
- Do you carry an epi-pen?
- Asthma
- Do you carry an inhaler?
- Blindness or Visual Problems
- Bone or Joint Problems
- Chest Pain
- Concussion or Serious Head Injury
- Diabetes
- Down Syndrome
- Atlanto-Axial Instability
- Easy Bleeding

Y N

- Emotional/Psychological/Behaviour Problems
- Hearing Loss/Hearing Aid
- Major Surgery or serious illness
- Heat Stroke/Exhaustion
- High Blood Pressure
- Medications (if yes, please indicate below)
- Non-Verbal
- Seizures/Epilepsy/Fainting Spells
If yes, date of last episode / /
(MM/DD/YY)
- If yes, commonly reoccurring
- Requires Assistance
- Uses Wheelchair
- Other _____

If you answered yes to any questions above, please elaborate in the boxes below:

Please explain any medical issues and how to address them (eg. List any allergies, response to seizures, ect., medications required for specific circumstances)

Please indicate any information that will benefit the athlete/coach training relationship (eg. Behaviour management, communications, limitations, ect.)

6. Medications (Please attach any additional information necessary)

Does athlete self-medicate? Yes No

Medication Name	Dosage	Times per Day
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Medication Name	Dosage	Times per Day
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Important: I understand that the information contained in this form may be deemed confidential. I affirm that I have read the above and that the information I have given is true and complete. This form must be completed and signed in order to participant in any practice or sporting event

Name (printed) _____ Signature _____

Relationship to Athlete _____ Date _____

Important: Information must be confirmed by the coaching staff or manager before the first practices of the year.

Date Information Confirmed Correct	Date Information Revised	Athlete/Guardian Initials	Coach/Manager Initials
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