GEORGIAN COLLEGE VARSITY ATHLETICS

Returning Male Athlete Medical Form

Varsity Team: _____

2015-16

Athletic Season

Last Name: _____ First Name: _____

Local Address: _____ City: _____ Prov.: _____ Postal Code: _____

Local Phone: ( ) _____ Email: _____ Age: _____

Date of Birth: _____ Prov, Health Card #: _____ Expiry Date: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Medications - Please list **ALL** prescribed and over-the-counter medications and supplements you are currently taking:

_____

_____

_____

Do you have allergies? ☐ Yes ☐ No If yes, please specify your specific allergy: _____

WITHIN THE PAST YEAR….. (Explain all "YES" answers in the space provided.)

GENERAL QUESTIONS	YES	NO	GENERAL QUESTIONS	YES	NO
1. Has a doctor denied or restricted your participation in sports for any reason?			15. Have you experienced coughing / wheezing with exercise?		
2. Have you been admitted to hospital for any reason?			16. Have you experienced frequent or severe headaches?		
3. Have you had surgery? Identify surgeries below.			17. Have you got lightheaded, dizzy or felt more short of breath than expected during exercise?		
4. Have you been advised to be on any medication on a regular basis? Identify medications in space below.			18. Have you experienced heat exhaustion or heat stroke?		
5. Have you been advised to be on any supplements/vitamins on a regular basis? Identify in space below.			19. Has a doctor ever ordered testing for your heart? (including ECG, EKG, ultrasound, etc.)		
6. Have you had a skin infection? Identify below what infection and when.			20. Have you experienced heart palpitations (when your heart feels as if it is pounding / racing)?		
7. Have you had any illness or medical condition lasting longer than one week? Explain below.			21. Have you experienced unexplained weight loss / gain?		
8. Have you had an injury requiring you to miss more than one practice or game?			22. Do you use any special equipment? (ie. brace, pads, orthotics)		
9. Have you had an injury requiring treatment / therapy?			23. Is there anything else you wish to discuss with the medical staff?		
10. Do you currently have an ongoing / incompletely healed injury?					
11. Have you had a concussion, or hit to the head causing confusion, headache, or memory problems?					
12. How many? When?					
13. Have you had numbness, tingling or weakness in your arms or neck injury after a hit or a fall?					
14. Have you ever been tested for a blood-bourne pathogen? (ie. HIV, Hep B or C) Please explain test results.					

Explain "YES" answer **s:** _____

_____

_____

_____

_____

_____

I hereby certify the above information to be correct. I understand that I may require further evaluation by a Sport Medicine Physician prior to varsity sports participation (practices / training camps etc.).

Athlete Signature: _____ **Date:** _____

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