



MEDICAL INFORMATION

LAST NAME: _____ FIRST NAME: _____

PERMANENT ADDRESS: _____ CITY, PROV. _____

LOCAL ADDRESS: _____ CITY _____ PHONE: _____

BIRTH DATE: _____ HEALTH INSURANCE NO. _____
DAY MONTH YEAR

IN EMERGENCY NOTIFY: _____ RELATIONSHIP: _____ PHONE: _____

FAMILY DOCTOR: _____ CITY: _____

MEDICATIONS AND ALLERGIES

List any current medications you are now taking, including vitamins, supplements and prescription drugs.

List any allergies you have (drugs, tape, insects, plants, foods) and describe what happens

<i>Substance</i>	<i>Reaction</i>
_____	_____
_____	_____

IMMUNIZATIONS

Please provide year of last immunization, indicate if you do not know

Tetanus _____ Unknown _____

Rubella _____ Unknown _____

VISION AND DENTAL HISTORY

Do you:	YES	NO		YES	NO
1. Wear glasses?	_____	_____	During Sport?	_____	_____
2. Wear contacts?	_____	_____	During Sport?	_____	_____
3. Have any other vision trouble?	_____	_____			
4. Wear a mouth guard for sports?	_____	_____			
5. Have denture / false teeth?	_____	_____			



ORTHOPAEDIC HISTORY

THE FOLLOWING QUESTIONS PERTAIN TO THE PAST YEAR ONLY

Please answer every question in this section by checking YES or NO.

HAVE YOU	YES	NO	ATHLETIC THERAPIST / DOCTORS NOTES		
1. Injured your head?					
2. Injured your neck?					
3. Injured your shoulder?					
4. Injured your clavicle?					
5. Injured an upper arm?					
6. Injured an elbow?					
7. Injured a forearm?					
8. Injured a wrist?					
9. Injured a hand?					
10. Injured a finger?					
11. Injured your abdomen?					
12. Injured a rib?					
13. Injured your back?					
14. Injured your hip?					
15. Injured a groin?					
16. Injured a thigh?					
17. Injured a hamstring?					
18. Injured a knee?					
19. Injured a lower leg?					
20. Injured an ankle?					
21. Injured a foot?					
22. Injured a toe?					
23. Had orthopedic surgery?					
24. Had surgery for a bone or joint with the result that you have a pin, plate or screw in your body?					
25. Been advised to have surgery but which has not yet been done?					
26. Been advised not to have surgery?					
27. Head Injury History (concussions)					
Year	Sport	Unconscious?	Hospitalized?	Notes:	
1					
2					
3					
4					
Release of Medical Information: I understand that any medical information relevant to my participation in athletic activities may be discussed with other physicians, therapists, trainers and coaches.					
ATHLETES SIGNATURE _____			DATE _____		



MEDICAL HISTORY

Please answer every question in this section by checking YES or NO.

Have you had any of the following in the past year (check all that apply)

	YES	NO		YES	NO
1. Smoking Habit			17. Collapsed Lungs		
2. Hepatitis			18. Chest Pain		
3. Diabetes			19. Shortness of Breath		
4. Rheumatic Fever			20. Irregular Heart Beat		
5. Heart Disease			21. Heart Murmur		
6. Kidney			22. Stomach Ulcer		
7. Asthma			23. Jaundice		
8. Epilepsy			24. Infectious Mononucleosis		
9. Gout			25. Intestinal Disorder		
10. Appendicitis			26. Venereal Disease		
11. Hernia			27. Back Pain		
12. Recurrent Headaches			28. Hives, Rash, Skin Infections		
13. Concussions			29. Mental or Nervous Disorder		
14. Blurred or Double Vision			30. Loss of Consciousness		
15. Recurrent Nose Bleeds			31. Cyst, Tumor, Growth, Cancer		
16. Dizziness			32. Other		
33. Did you experience an injury to your brachial plexus area of your shoulder last season? IF SO, HOW MANY _____					
34. Have you ever experienced any tingling or numbness down any of your limbs (arms or legs)? IF SO, WHERE _____					
35. Have you ever experienced a fainting episode?					
36. Have you ever suffered heat exhaustion / heat stroke? IF SO, WERE YOU HOSPITALIZED? _____					
37. Have you ever experienced unintentional weight loss?					
38. Have you ever had or have excessive urination or excessive thirst?					
39. Have you ever had a blood transfusion?					
40. On average, how many alcoholic drinks do you consume weekly?					
41. Do you use chewing tobacco?					

Family History

YES NO

42. Has any member of your family died suddenly during sports participation?		
43. Has any member of your immediate family (Father, Mother, Sister, Brother) had any of the following illnesses? If the answer is yes, please circle the illness		

- | | | | | |
|-----------|---------|---------------|----------------|---------------------|
| Diabetes | Goiter | Gout | Kidney Disease | Neuro. Disorder |
| Allergy | Cancer | Tuberculosis | Mental Illness | High Blood Pressure |
| Arthritis | Obesity | Heart Disease | Blood Disorder | Sickle Cell Anemia |

Female Only – Menstrual and Gynecological History

- Age of first menstrual period? _____ yrs
- Have your periods been regular? YES NO If yes, how far apart are your periods _____ days
- Have your periods been irregular? YES NO If yes, please explain _____
- Are you on the birth control pill (BCP)? YES NO If yes, Name of BCP _____
- Have you ever had a pap test? YES NO Date of last pap test _____



Wilfrid Laurier University
Medical Staff Recommendation Form
Intercollegiate Athletic Pre-Participation Screening

NAME: _____ AGE: _____
SPORT: _____ POSITION: _____
VARSITY YEAR: 1 2 3 4 5+

DATE: _____
Part 1 Clearance
Based on the following information follow up form, this athlete is:
[] Cleared to play – no restrictions
[] Cleared to play – with restrictions
[] Disqualified: _____ Temporary or _____ season
[] Clearance Deferred pending following referral / investigation
Therapist/Physician (print) _____
(signature) _____

DATE (DD/MM/YYYY): ____ / ____ / _____ Vision: Lft Eye _____ Rt Eye _____
HT: _____ (ft/in) WT: _____ (lb) HR: _____ (bpm) BP: _____