Netball Alberta Medical Form

Team/Position: ________________________________

Personal Information:

Name: (Last, First, Middle) _________________________ **Sex: Male** ☐ **Female** ☐

Address: ____________________________________ **Date of Birth: (Y/M/D)** ______________

____ **Blood Group/Type:** ______________

Tel: Home_______________ **Cell**___________________ **Alberta Health #:** ______________

Occupation: ____________________________________ **Date of Tetanus Booster:** __________

Emergency Contact: _____ _____________________ **Tel: Home** __________ **Cell** __________
(Relationship to you)

Family Doctor: ______________________________ **Tel:** ________________ **Fax:** ___________

Address: ____

Medical History:

Have you ever had (even as an infant/child) or now have any of the following:

		Yes	No				Yes	No
Head Injury					Diabetes			
Seizures					Blood Transfusions			
Back/Neck Disorder					Hepatitis			
Fainting					Thyroid Disorder			
Psychiatric Disorder					Ulcers			
Eye Problems					Bowel Problems			
Glasses/Contacts					Urinary Infections			
Nose Bleeds					Kidney Problems			
Dental Problems					Menstrual Disorder			
Deafness/Hearing Concerns								
Asthma					**Within Last Year**			
Bronchitis								
Chest Pains					Infectious Diseases			
Heart Problems					Head Injury			
					Surgery			

If you answered 'yes' to any of the above, please describe: ______________________________

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Does anyone in your family have any of the above (ie. seizures, heart conditions, psychiatric disorder etc.)? If 'yes' please give details: ___________________________________

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Medications and Herbal Supplements/Vitamins Currently Taken: ______________________________
(Include Name & Dosage)

Allergies: (Include latex or tape) ____

What medication do require for this allergy: ____

What reaction do you have?
____

Date of last Menstrual period? ____

Do you wear contact lenses or a removable dental apparatus? ______________________

Have you ever had a Concussion? Yes ☐ No ☐

If 'yes' when was the most recent concussion? ______________________________

How long were you unconscious for? ______________________________

How many in total have you had? ______________________________

Current Status:

Previous Injuries (are braces needed?): ____

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Current Injuries (what treatments are you receiving?): ____

Physiotherapy Needs (Taping Requests?): ____

Certification and Consent:

I certify that I have made a full and complete disclosure concerning any and all of my medical conditions, medications, allergies and injuries. I have answered all questions honestly and truthfully.

I consent to the release of all information contained in, or arising from, this medical questionnaire to the appropriate members of the support staff of Netball Alberta/Netball Canada and the associated medical/training staff.

Signature: ______________________________ Date: ______________

Parent/Guardian Signature: ______________________________
(If athlete under 18 years of age)