



# Property of the **Jr A Mountaineers Lacrosse Club**

## **Jr A Mountaineers Medical Forms**

### **I. PERSONAL DATA**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Health Care #: \_\_\_\_\_  
 \_\_\_\_\_ Height (ft): \_\_\_\_\_  
 D.O.B. (dd/mm/yyyy): \_\_\_\_\_ Weight (lb.): \_\_\_\_\_

### **II. EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone# (h): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone# (w): \_\_\_\_\_  
 Relation: \_\_\_\_\_ Phone # (c): \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Family Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

### **III. MEDICAL CONDITIONS**

Indicate "yes" or "no" to the following questions by placing an X in the appropriate box.

	<b>YES</b>	<b>NO</b>
Have you even been hospitalized?		
Do you have any allergies (medicine, bees, food)?		
Do you or any of your family members have high blood pressure?		
Have you been told that you have a heart murmur?		
Do you or any family members have a history of heart problems?		
Do you have any skin problems (itching, rashes, acne)?		
Have you passed out or been dizzy during or after exercise?		
Do you have any medical conditions that affect participation (diabetes, epilepsy, asthma)?		
Have you had a head injury?(ie: concussion)		
Have you ever passed out during or after exercise?		
Have you ever had a stinger, burner, or pinched nerve?		
Have you ever had heat cramps or muscle cramps?		
Have you had a medical problem since you last had a physical exam?		

Explain "yes" answers you have given:

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**IV. CONDITIONS**

Have you injured any bones, joints or muscles that required medical attention? Please explain:

Body Area	Specific Injury	R or L Side	Treatment and Date (month/year)

	YES	NO
Do you wear any special equipment (braces, splints, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for any medical conditions in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a dental appliance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a medical alert bracelet?	<input type="checkbox"/>	<input type="checkbox"/>

List the Medications you are currently taking

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**V. CONSENT**

I, \_\_\_\_\_ (athlete's name) have completed the medical form to the best of my knowledge and I have not willingly withheld information on my condition or injury for which I have had in the past or am currently being treated. I recognize the importance of the medical information in assisting the Head Therapist in providing prompt and accurate medical attention. I am aware the therapist attending to my team might need to clarify any previous condition or

injury that I have sustained. I understand that the head therapist will keep this information confidential unless it is necessary to divulge it to another medical practitioner/ medical facility. I also understand that the therapist might need to share relevant medical history with the coaching staff that directly affects my participation in this sport.

I understand that the therapist is not responsible for the state of my condition should I refuse to accept the therapist's advice.

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Athlete's Signature

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Date

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Parent's Signature (required if under 18)

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Date