



Player Medical History Form

Players Full Name _____

Address _____

Phone # _____ Cell # _____

Care Card # _____

Family Physician _____ Phone _____

Emergency Contact _____ Phone _____

Cell _____

OUTLINE PAST HISTORY OR ILLNESS

Any "YES" please specify below

HAVE YOU EVER HAD OR DO YOU NOW HAVE

	YES	NO
KNEE, HIP, ANKLE, SHOULDER, ARM, NECK,	_____	_____
BACK, INJURIES/OPERATIONS	_____	_____
CARDIAC PROBLEMS	_____	_____
NECK/BACK DISORDER	_____	_____
FAINTING SPELL	_____	_____
EYE PROBLEMS	_____	_____
GLASSES/CONTACT	_____	_____
NOSE BLEEDS	_____	_____
DEAFNESS/EAR PROBLEMS	_____	_____
ASTHMA	_____	_____
BROCHITIS	_____	_____
DIABETES	_____	_____
NEUROLOGICAL PROBLEMS (Epilepsy, migraines)	_____	_____
ON MEDICATION NOW	_____	_____
ALLERGIES	_____	_____

Please List anything the coach should be aware of about your child.