CPFA HEALTH QUESTIONNAIRE

1. PERSONAL DATA

Name: _____ Phone #: _____

Address: _____ AHCI# _____

_____ Prov. _____

GENDER: F ____ M ____ Date of Birth: _____ (d/m/y)

2. **EMERGENCY CONTACT**:

Name: _____ Phone # (h) _____

Address: _____ Phone # (w) _____

Relation: _____

Family Physician _____ Phone # _____

Family Dentist _____ Phone # _____

3. MEDICAL CONDITIONS

Indicate "yes" or "no' to the following questions and explain any "yes" answers

Have you ever been hospitalized?	Yes No
Do you have any allergies (medicine, bees, or other stinging insects)	Yes No
Do you or any of your family members have high blood pressure?	Yes No
Have you been told that you have a heart murmur?	Yes No
Do you or any family members have a history of heart problems?	Yes No
Do you have any skin problems (itching, rashes, acne)?	Yes No
Have you passed our or been dizzy during or after exercise?	Yes No
Do you have medical conditions that affect participation? (diabetes, Epilepsy, asthma)?	Yes No
Have you had a head injury (ie. Concussion)?	Yes No
Have you ever passed out during or after exercise?	Yes No
Have you ever had a stinger, burner, or pinched nerve?	Yes No
Have you ever had heat cramps or muscle cramps?	Yes No

Have you had medical problems since your last physical?

Explain any "yes" answers you have given: _____

_____

4. ORTHOPAEDIC CONDITIONS

If you have injured any bones, joints, or muscles that require medical attention, please elaborate:

Body Area	Specific Injury	Rt or Lt	Date
Head/Neck			
Shoulder/Arm			
Wrist/Hand/Fingers			
Chest			
Back			
Pelvis/Hip			
Thigh			

Knee _____
Shin/Calf _____
Foot/Toes _____

Do you wear any special equipment (braces/splints/eye guards/etc)	Yes	No
Do you wear glasses, contacts, or protective eyewear?	Yes	No
Are you presently taking any medications or pills?	Yes	No
Have you missed five (5) games in a row due to injury?	Yes	No
Have you been treated for any medical conditions in the past Three months?	Yes	No
Do you wear a dental appliance?	Yes	No
Do you wear a medic alert bracelet?	Yes	No

List the medications that you are taking for the above mentioned medical conditions or injuries:_____
How long have you been participating in this sport? _____
What other sports do you participate in? _____

5. CONSENT

I, _____ , parents/guardian of _____ have completed the medical questionnaire to the best of my knowledge and have not willingly withheld information on any condition or injury for which my child has had in the past or am currently being treated. I recognize the importance of the medical questionnaire in assisting the coaches in providing prompt and accurate medical attention. I am aware that the team staff member attending to my child's injury may need to clarify any previous condition or injury that my child has sustained. I understand that this information will be kept confidential unless it is necessary to divulge it to another medical practitioner/medical facility.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date