

Athlete Medical Profile - Personal Record

All information on this sheet is confidential.
Access to this sheet is limited to Director, Sports First Aider, Sports Trainer and Coach.

Personal Details

Surname	<input type="text"/>	Given Names	<input type="text"/>
Address	Number <input type="text"/>	Street / Road <input type="text"/>	
	Suburb / Town / City <input type="text"/>		State <input type="text"/> Postcode <input type="text"/>
Home Phone	Area Code <input type="text"/> Number <input type="text"/>	Mobile / Business Phone	Number <input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/>
		Age	Years <input type="text"/>
		Height	Centimetres <input type="text"/>
		Weight	Kilograms <input type="text"/>
Blood Group	<input type="text"/>	Do you object to transfusions?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Emergency Contact

Surname	<input type="text"/>	Given Names	<input type="text"/>
Home Phone	Area Code <input type="text"/> Number <input type="text"/>	Mobile / Business Phone	Number <input type="text"/>
Relationship	<input type="text"/>		

Health Care Details

Medicare Number	<input type="text"/>	Private Health Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fund	<input type="text"/>
Private Doctor	<input type="text"/>	Telephone	Area Code <input type="text"/>	Number	<input type="text"/>
Address	Number <input type="text"/>	Street / Road <input type="text"/>			
	Suburb / Town / City <input type="text"/>		State <input type="text"/>	Postcode <input type="text"/>	
Can Doctor be contacted at all times? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Private Dentist	<input type="text"/>	Telephone	Area Code <input type="text"/>	Number	<input type="text"/>
Address	Number <input type="text"/>	Street / Road <input type="text"/>			
	Suburb / Town / City <input type="text"/>		State <input type="text"/>	Postcode <input type="text"/>	
Can Dentist be contacted in emergency? Yes <input type="checkbox"/> No <input type="checkbox"/>					

Current History

Current medical problems

Regular medications including supplements, stating name and dosage

Allergies

Sports injuries (Please list any injury which is current/recurring or requires surgery)

Past History

Have you had ...

- Epilepsy Yes No
Diabetes Yes No
Heart Problems Yes No
Heart Murmur Yes No
Asthma/Bronchitis Yes No
Hernia Yes No
Concussion Yes No

Do you wear ...

- Glasses Yes No
Contact Lenses
Soft Yes No
Hard Yes No
Protective Equipment Yes No
Mouth Guard
at training Yes No
at competition Yes No
Other Yes No

If yes, please specify

Have you sustained ...

A fracture in last 3 years Yes No

If yes, where?

A dislocation Yes No

If yes, where?

Do you suffer from ...

Recurring pain in any joint or muscle with play/practice? Yes No

If yes, where?

Back / Neck pain Yes No

Have you ever been treated for a head, neck or spinal injury? Yes No

Details

Does this condition affect your performance?

*To the best of my knowledge, all information contained on this sheet is correct
(if under 18 please have parent or legal guardian sign)*

Signature

Date