CARLETON UNIVERSITY ATHLETICS
MEDICAL HISTORY AND EXAMINATION

(To be completed by athlete)

NAME F/L_____ DATE OF BIRTH d____/m_____/yr_____STUDENT NUMBER _____ SEX _____

SPORT_____ PRESENT ADDRESS _____ POSTAL CODE _____

PHONE NUMBER _(___)_____ (___)_____ PROV. HEALTH NO. _____Prov _____
Present Permanent OHIP include letters and exp. date

PERMANENT ADDRESS _____ POSTAL CODE _____ E-MAIL_____
(if different for above)
FOR EMERGENCY NOTIFY: Name_____ Relationship _____ TELEPHONE _(_____)_____

FAMILY PHYSICAN _____ PHONE NUMBER_____DATE of last Physical (Month Year) _____

Answer all the questions below checking appropriate box

CONDITION	NO	YES	If " YES" indicate what, where and when
Allergies to medications, insect bites, food etc.			
On medications prescription or non prescription			
Only one of normally paired organs (eye, kidney)			
Wear a medical alert tag			
Been advised not to play a sport			
Head injury (concussion) how many: long term effects?			
Fainting, dizziness, blackouts			
Numbness, tingling (any part of the body)			
Heat related problems			
Medical conditions or injuries in last 12 months			
Epilepsy, seizures, convulsions			
High blood pressure			
Heart problems (murmur, palpations)			
Breathing problems (asthma) inhaler?			
Have any severe viral infections (mono, myocarditis)			
Surgery (other than tonsils)			
Hospitalization (recent)			
Wear glasses, contacts while playing?			
Wear any dental appliance			
Hearing defects or ear problems			
Wear any type of protective device (brace)			
Frequent headaches			
Coordination /balance problems			
Have you had any problems with your eyes or vision			
Family history of heart problems or other			
Family member died suddenly before age 50			
Chronic joint problems			
Broken bones which ones			
Hernia or rupture			
Any injuries that should be reported (acute or chronic)			
AIDS or tested HIV positive			
Conditions affecting your abdomen or internal organs			
Emotional problems			
Recent weight change (+/-)			
Type frequency of exercise program			
History of disordered eating			
Any excessive thoughts about weight or appearance			
Satisfied with current weight			
FEMALES ONLY			
Any history of menstrual dysfunction			
Anemia			

CERTIFICATION:

I the undersigned, hereby certify that I have made a full and complete disclosure in answering all of the questions above to the best of my knowledge.

Signature_____ Date _____

I the undersigned authorize the professional staff of Carleton University Athletic Therapy to release to my coaches and /or the administration of the Department of Athletics, information contained on this form, or other information about my health status, as it relates to my participation as a member of a Varsity sport team . I am aware that this general permission can be revoked by a specific request to the Head Athletic Therapist to withhold specific information.

Signature _____ Date _____