Medical History Card

Name: _____Birthdate: _____

Address: _____

_____ Phone: _____

Personal Health Number: _____ Expiry: _____

Parent/Guardian Name: _____

Address (If different from above): _____

Phone: _____ Ph Work: _____

Family Physician: _____ Phone: _____

Record of illness. State illnesses or conditions, past or present, that may affect or be affected by performance.

Asthma ☐ Diabetes ☐ Heart Disease ☐ Seizures ☐

Other: _____

_____

(Specify) Other previous injuries, surgery, or conditions:

Headaches ☐ Blackouts ☐ Chest Pain ☐ Fractures ☐

# of concussions: _____

Other: _____

Corrective lenses required? No ☐ Yes ☐

Immunization: Year of last tetanus shot: _____

List allergies and/or medications taken regularly: _____

_____

_____

Date card completed: _____

Signature of parent or guardian: _____