St. Jude's Football Club
Player Medical History Form

SURNAME:______________________________________ GIVEN NAME: ___________________________________

ADDRESS:______________________________________ DATE OF BIRTH (MM//DD/YY): ______________________

______________________________________ HEIGHT: ________________WEIGHT: ________________

______________________________________ BLOOD GROUP & TYPE: __________________________

HEALTH CARD NO: ______________________________ MEDICAL INSURANCE TEL NO: ____________________

POLICY NO: _____________________________________

FAMILY PHYSICIAN: _____________________________ PHONE: ____

NEXT OF KIN: __________________________________ PHONE: ____

IN CASE OF EMERGENCY
PLEASE NOTIFY: ________________________________ PHONE: ____

OUTLINE PAST HISTORY OR ILLNESS

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	YES	NO
HEAD INJURY	___	___
SEIZURES	___	___
NECK/BACK DISRODER	___	___
FAINTING SPELLS	___	___
PSYCHIATRIC DISORDER	___	___
EYE PROBLEMS	___	___
GLASSES/CONTACTS	___	___
NOSE BLEEDS	___	___
DENTAL PROBLEMS	___	___
DEAFNESS/EAR PROBLEMS	___	___
ASTHMA	___	___
BRONCHITIS	___	___
CHEST PAINS	___	___
HEART PROBLEMS	___	___
ULCERS	___	___
BOWEL PROBLEMS	___	___
URINARY INFECTIONS	___	___
KIDNEY PROBLEMS	___	___
MENSTRUAL PROBLEMS	___	___
EATING DISORDERS	___	___

	YES	NO
DIABETES	___	___
BLOOD TRANSFUSIONS	___	___
HEPATITS	___	___
THYROID DISORDER	___	___
ALLERGIES (SPECIFY)	___	___
FRACTURES (SPECIFY)	___	___
OPERATIONS (SPECIFY)	___	___
RECENT WITHIN ONE YEAR:		
INFECTIOUS DISEASE	___	___
HEAD INJURY	___	___
MAJOR SURGERY	___	___
TRAUMATIC OR OVERUSE INJURY	___	___

Please list below any other health issues or relevant information. Please explain below any conditions marked “Yes” above.

MEDICATIONS CURRENTLY USED

DATE COMPLETED: ________________________

PRESCRIBED:____

NON PRESCRIBED:_______________________________________ SIGNATURE OF PARENT/GUARDIAN: ________________________