## A.B.J SCOTS

## **Football Alberta Medical Form**

(Side "A" – Personal Information to be filled out by *you!*)

Answer all of the questions below by checking YES or NO HAVE YOU EVER HAD OR DO YOU NOW HAVE  Yes No Irregular Heart Beats Infectious Mononucleosis Scarlett or Rheumatic Fever A heart murmer Inostillitis/Sinusitis Ear or Hearing Trouble Coughed up blood Asthma Frequent or Severe Headaches Severe tooth or gum troubles Inogenation of the severe of the severe Headaches Severe tooth or gum troubles Severe tooth or gum troubles Inogenation of the severe Headaches Severe tooth or gum troubles Inogenation of the severe Headaches Severe tooth or gum troubles Inogenation of the severe Headaches Severe tooth or gum troubles Inogenation of the severe Headaches of the severe Headaches of the severe Headaches of the severe Headaches and the severe Headaches and the severe Headaches the severe Headaches the severe Headaches and the severe Headaches the severe Headaches the severe Headachesear and the severe Headaches the severe Headaches the severe He	Date of Birth (dd/mm/yyyy):	
Alberta Heath Care Number:		
Emergency Contact (Name):		
Emergency Contact Phone Number:	UT!!!!!	
Family Doctor's Name: Family Doctor's Address: Pamily Doctor's City/Town: Postal Coc Answer all of the questions below by checking YES or NO HAVE YOU EVER HAD OR DO YOU NOW HAVE  Yes No Irregular Heart Beats Infectious Mononucleosis High or low blood pressure A heart murmer Scarlett or Rheumatic Fever A heart murmer Difficulties with vision Difficulties or Epilepsy or fits Dizziness or fainting spells Poeumonia or Tuberculosis Scarlett or Users Dizziness or fainting spells Poeumonia or Tuberculosis Scarlett or Users Dizziness or fainting spells Poeumonia or Users Dizziness or fainting spells Poeumonia or Users Dizziness or fainting spells Poeumonia or User trouble Loss of Memory Dienemonia or User Users Dizziness or fainting spells Poeumonia or Users Dizziness or fainting spells Poeumonia or User Users Dizziness or fainting spells Poeumonia or User Users Dizziness or fainting spells Poeumonia or User Users Dizziness or fainting spells Poeumonia or Users Dizziness or fainting spells Poeumonia or User Users Dizziness or fainting spells Poeumonia or Users Dizziness Dizzine		
Family Doctor's City/Town:		
Answer all of the questions below by checking YES or NO HAVE YOU EVER HAD OR DO YOU NOW HAVE  Yes No  Heat Stroke/Cramps Infectious Mononucleosis  Scarlett or Rheumatic Fever  Tonsillitis/Sinusitis  Coughed up blood  Asthma  Frequent or Severe Headaches  Severe tooth or gum troubles  Severe tooth or gum troubles  Stomach Ulcers  Pheumonia or Tuberculosis  Anemia or low iron  Hepatitis or liver trouble  Hemia or rupture  Sus dalcohol  Trequent or Severe blood urine  Frequent or Severe blood urine  Herough or painful urination  Sexually transmitted disease  Allergies  Arthritis  Any other medical illness  Yes  Have you ever had any surgery? If YES, what for?  Have you ever had any broken bones? If YES, which dones?  Do you have an eye condition that requires a tinted visor white or a plate?  Presum on your bond or a plate?  Presum or point surgery? If YES, where?  Do you have an eye condition that requires a tinted visor white playing football?  If YES, where?  Do you wear any dental appliances such as braces or a plate?		
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Yes   No   Irregular Heart Beats   Irregular Beats   Irreg		
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Do you wear any dental appliances such as braces or a plate?		
FAMILY HIGTORY Places similar and illustrated that have affected (		
FAMILY HIGTORY Disease shall and the control of the		
FAMILY HISTORY: Please circle any illnesses that have affected family members past or present.		
Diabetes, Allergies, Arthritis, Neurological Disorders, Gout, Heart Disease, High Blood Pressure, High Cholesterol,		
Bleeding Problems, Kidney Disease, Mental Illness, Sickle Cell Anemia		
YES No Has anyone in your family died suddenly before the age of 40?		
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YE YOU TAKING ANY MEDICATIONES KYES Shases list	-	
ARE YOU TAKING ANY MEDICATIONS? If YES, please list		
ARE YOU TAKING ANY SUPPLIMENTS? If YES, please list		
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? If YES, please list		
DO YOU HAVE ANY OTHER ALLERGIES (i.e. bees)? If YES, please list		
WHEN WERE YOUR IMMUNIZATIONS LAST UPDATED (Including Tetanus) (dd/mm/yyyy)		
CHECK ANY OF THE AREAS THAT YOU HAVE INJURED IN THE PAST AND EXPLAIN THE INJURY BELOW:		
Hand	Foot	
Arm Chest Thigh Ankle Forearm Shoulder Back	Neck_	
AIII Criest ITiign ATikle Foreariii Shouldei Back		