FIRST-YEAR STUDENT-ATHLETES MEDICAL FORM

HIGH RISK SPORTS

TO BE COMPLETED BY THE ATHLETE:

Athlete's Name: ______________________________________

McMaster Student Number: ___________________________

Team: _______________________________________

TO BE COMPLETED BY THE PHYSICIAN:

This form hereby certifies that __________________________________ has been medically cleared to participate as an athlete for McMaster University. I understand that participating in Athletics involves a high level of physical training. I have completed a full medical exam on this athlete and I declare that he/she is medically sound for full participation in athletics.

______________________________ ___________________

PHYSICIAN'S SIGNATURE **DATE**

*TO BE COMPLETED BY PHYSICIAN'S OFFICE **PLEASE PRINT***

Name of attending physician: ____

Clinic Address: ____

Clinic Phone Number: ____

FIRST YEAR MCMASTER UNIVERSITY ATHLETE MEDICAL FORM

****This must be completed PRIOR to starting any varsity / club season -- this INCLUDES ANY TRYOUT SESSIONS. Failure to complete and submit these forms may affect your eligibility to participate as an athlete for McMaster University****

For the purposes of McMaster University Athletics & Recreation, a "high risk" sport is defined as:

A sporting activity involving a collision of bodies and/or equipment moving at a high velocity which is likely to result in frequent severe injury OR a sport where a foul is not assessed to a player for that bodily contact because it is inherent to the sport and an allowable part of play.

The following sports are considered "high-risk" at McMaster University:

- Basketball
- Cheerleading
- Football
- Hockey
- Lacrosse
- Rugby
- Soccer
- Wrestling

GREY AREAS TO BE COMPLETED BY THE ATHLETE
WHITE AREAS TO BE COMPLETED BY THE PHYSICIAN

Last Name:	**First Name:**
Student Number:	
Permanent Address:	**Postal Code:**
Phone Number:	**Email:**
Birth Date:	**Gender:**
Sport:	**Years of University Competition:**
Health Card #:	**Version Code** (upper case letters beside #):
Health Card Expiry Date:	
Emergency Contact Name:	**Emergency Contact Relationship:**
Emergency Contact Address:	**Emergency Contact Phone Number:**
Family Doctor's Name:	**Phone Number:**

DO YOU/HAVE YOU EVER BEEN REQUIRED TO:	*Yes*	*No*
Wear glasses/contact lenses		
Been required to wear a hearing aid		
Been required to wear a removable denture appliance		
Had any childhood diseases – measles, mumps, chicken pox		
Been advised not to participate in competitive sports**		
Had issues around your weight as it regards to your sport		
Had irregular menstrual cycle		

** If yes, please provide details: ____

____

____

MEDICAL HISTORY:	*Yes*	*No*		*Yes*	*No*
Smoking			Shortness of Breath		
Hepatitis			Irregular Heart Beat		
Diabetes			Heart Murmur		
Kidney Problems			Stomach Ulcer		
Asthma			Jaundice		
Epilepsy			Infectious Mononucleosis		
Appendicitis			Intestinal Disorder		
Hernia			Severe Weight Loss		
Recurrent Headaches			Back Pain		
Concussion / Bell Ringer			Hives, Rash, Skin Infection		
Blurred / Double Vision			Mental or Nervous Disorder		
Recurrent Nose Bleeds			Loss of Consciousness		
Dizziness			Cyst / Tumour / Growth / Cancer		
Numbness in Arms / Legs			Burners or Stingers		
Collapsed Lung			HIV / AIDS		
Chest Pain			Other		

If you have answered ‘yes’ to any of the above, please provide details: ____________________________

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FAMILY HISTORY:	***Yes***	***No***
Has any member of your family died suddenly?		
Has any member of your immediate family had any of the following illnesses: (If yes, circle the illnesses) Allergy / Blood Disorder / Goiter / High Blood Pressure / Neurological Disorder Anemia / Cancer / Gout / Kidney Disease / Obesity Arthritis / Diabetes / Heart Disease / Mental Illness / Tuberculosis		

If you have answered 'yes' to any of the above, please provide details: ____________________________
____
____

ORTHOPEDIC HISTORY:
Player must answer every question in this section by checking 'yes' or 'no'. "Yes" answers require that you fully explain the injury to the examining physician.

Have you ever injured…	***Yes / No***	***Year***	***Lt/Rt***	***Treatment***	*Dr's Notes (please note if you are clearing the patient* ***from this injury)***
… your head					
… your neck					
… your shoulder					
… an upper arm					
… an elbow					
… a forearm					
… a wrist					
… a hand					
… a finger					
… your abdomen					
… a rib					
… your back					
… a hip					
… a groin					
… a thigh					
… a hamstring					
… a knee					
… a lower leg					
… an ankle					
… a foot					
… a toe					

Have you ever…	***Yes / No***	***Year***	***Lt/Rt***	***Dr's Notes** (please note if you are clearing the patient from this injury)*
…had orthopedic surgery?				
…had surgery for a bone or joint resulting in a pin, screw or plate in your body?				
…been advised to have surgery, but has not been done?				
…been advised NOT to have surgery?				

MEDICAL EXAMINATION (To be completed by the physician):

Position:	Blood Pressure:
Height:	Weight:
Allergies (to Drugs):	Allergies (other):
Current Medications / Supplements / Vitamins:	
Immunizations (current): Yes O No O Updated on:	Last Tetanus:

PHYSICAL EXAM:

Area	***Normal***	***Abnormal***	***Doctor's Notes***
Head			
Eyes			
ENT			
Neck			
Chest			
Cardiovascular			
Abdomen			
Genito/Urinary			
Skin			
Central Nervous System			
Psyche			

ORTHOPEDIC EXAMINATION:

Area		***Normal***	***Abnormal***	***Doctor's Notes***
Head				
Shoulders	Right			
	Left			
Elbows	Right			
	Left			
Wrist	Right			
	Left			
Hands	Right			
	Left			
Fingers	Right			
	Left			
Neck Cervical				
Back	Thoracic			
	Lumbar			
	Sacrum			
	Coccyx			
Chest				
Groin	Right			
	Left			
Thigh	Right			
	Left			
Hamstring	Right			
	Left			
Lower Leg	Right			
	Left			
Ankle	Right			
	Left			
Foot	Right			
	Left			

KNEE

Area		*Normal*	*Abnormal*	*Doctor's Notes*
Range of Motion (Flexion)	Right			
	Left			
Range of Motion (Extension)	Right			
	Left			
Drawer	Right			
	Left			
Stability	Right			
	Left			
Collateral Ligaments	Right			
	Left			
Anterior Cruciate	Right			
	Left			
Effusion	Right			
	Left			
Patellar Crepitus	Right			
	Left			

Certification

As required by McMaster University, I certify that I have made full disclosure concerning any and all illnesses and injuries, that I understand the form and I have answered completely and truthfully any and all questions asked of me by the attending physician.

______________________________ ______________________________

Date ***Player***

______________________________ ______________________________

Date ***Attending Physician***

Consent

The player, by his/her signature hereby consents to the release of this and other relevant medical information, including any operative reports and hospital records to McMaster University Sports Injury Clinic, Department of Athletics and Recreation. This consent to release medical information is required by the Personal Health Information Protection Act. (A copy of this Act can be obtained on request.)

______________________________ ______________________________

Date ***Player***

MCMASTER SPORTS INJURY CLINIC
PRIVATE HEALTH INSURANCE INFORMATION

NOTE: *AS A VARSITY ATHLETE YOU ARE NOT PERMITTED TO OPT OUT OF THE SCHOOL HEALTH INSURANCE PLAN.*

Name: ______________________________ ***Student Number:*** ________________

*Date of Birth:*________________________ *Sport:* __________________________

Do you or your parents have any private health insurance coverage: YES O NO O

If YE, please complete the following in detail (failure to provide details will result in the impression there is no coverage **Please contact your insurance company directly if necessary**)

Name of Insurance Company:	
Name of Policy Holder:	**Policy Holder's Date of Birth:**
Policy Number:	**Member ID:**
Year End Reset Date:	
Until what age are you considered dependent on this plan:	
Is a doctor's referral required? Yes O No O	

In the chart below, please check off the areas in which you receive private insurance, as well as the requested information. You may have to contact your insurance company directly for all information

		Maximum Number of Visits	Maximum Cost per visit	% covered	Annual Max
O	Physiotherapy				
O	Athletic Therapy				
O	Chiropractic				
O	Ostopathy				
O	Massage Therapy				
O	Orthotics				
O	Dental (Mouth Guards)				