



TEAM: _____ **YEAR:** _____

**CALGARY SPRING FOOTBALL ASSOCIATION (CSFA)
HEALTH QUESTIONNAIRE FORM**

It is required that this form be completed and submitted prior to ANY participation in any physical activity with a CSFA team.

I. PERSONAL DATA

Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
Health Care #: _____
Gender: **F** **M** Date of Birth (MON/D/Y): _____ HT: _____ WT: _____

II. EMERGENCY CONTACT

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
Relation: _____ Cell Phone: _____
Family Physician: _____ Phone #: _____
Family Dentist: _____ Phone #: _____

III. MEDICAL CONDITIONS

Indicate "yes" or "no" to the following questions and explain any "yes" answers.

YES NO

- Do you have any allergies (medicine, bees or other stinging insects)? YES NO
- Do you or any of your family members have high blood pressure? YES NO
- Have you been told that you have a heart murmur? YES NO
- Do you or any family members have a history of heart problems? YES NO
- Do you have any skin problems (itching, rashes, acne)? YES NO
- Have you passed out or been dizzy during or after exercise? YES NO
- Do you have medical conditions that affect participation (diabetes, epilepsy, asthma)? YES NO
- Have you had a head injury (i.e. concussion)? YES NO
- Have you ever had a stinger, burner, or pinched nerve, heat or muscle cramps? YES NO
- Have you been treated for any medical conditions in the past three months? YES NO
- Do you wear a dental appliance or a medic alert bracelet? YES NO

Explain any "yes" answers you have given:

IV. ORTHOPAEDIC CONDITIONS

If you have injured any bones, joints or muscles that required medical attention, please elaborate:

Body Area	Specific Injury	Rt./Lt. Side	Date (M/Y)
Head / Neck			
Shoulder / Arm			
Wrist / Hand / Fingers			

ORTHOPAEDIC CONDITIONS – cont'd

Body Area	Specific Injury	Rt/Lt Side	Date (M/Y)
Chest			
Back			
Pelvis / Hip			
Thigh			
Knee			
Shin / Calf			
Foot / Toes			

- Do you wear any special equipment (braces, splints, eye guards, etc.)?
- Do you wear glasses, contacts, or protective eyewear?
- Are you presently taking any medications or pills?
- Have you missed five (5) games in a row due to injury?
- Have you been treated for any medical condition(s) in the past three (3) months?

List the medications you are taking for the above-mentioned medical condition(s) or injury(ies):

How long have you been participating in this sport? _____

What other sports do you participate in? _____

V. CONSENT

I, _____, (athlete's name), together with my parent(s) have completed the medical questionnaire to the best of our knowledge and have not willingly withheld information on any condition or injury for which the athlete has had in the past or is currently being treated for. We recognize the importance of the medical questionnaire in assisting Athletic Therapist(s), First Aiders, Emergency Medical Care...etc. in providing prompt and accurate medical attention. We are aware that any medical professionals attending to the athlete's care may/will need to clarify any previous condition(s) or injury(ies) the athlete may have sustained. We understand that this information will be kept confidential unless it is necessary to divulge it to a medical practitioner / medical facility.

We also understand that the Calgary Spring Football Association (CSFA) is not responsible for the state of the athlete's condition should the athlete and/or parent(s) refuse to accept the advice from medical professionals at the scene.

Athlete's Signature

Date

Parent/Legal Guardian's Signature

Date

Witness Signature

Date