

Athlete Medical Profile - Personal Record

*All information on this sheet is confidential.
Access to this sheet is limited to Director, Sports First Aider, Sports Trainer and Coach.*

Personal Details

Surname											Given Names																			
Address	Number					Street / Road																								
	Suburb / Town / City																				State			Postcode						
Home Phone	Area Code		Number								Mobile / Business Phone										Number									
Sex	M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth								Age			Years		Height			Centimetres		Weight			Kilograms						
Blood Group						Do you object to transfusions?										Yes <input type="checkbox"/>			No <input type="checkbox"/>											

Emergency Contact

Surname											Given Names																	
Home Phone	Area Code		Number								Mobile / Business Phone										Number							
Relationship																												

Health Care Details

Medicare Number						Private Health Insurance					Yes <input type="checkbox"/> No <input type="checkbox"/>		Fund																						
Private Doctor																					Telephone					Area Code		Number							
Address	Number					Street / Road																													
	Suburb / Town / City																				State			Postcode											
Can Doctor be contacted at all times? Yes <input type="checkbox"/> No <input type="checkbox"/>																																			
Private Dentist																					Telephone					Area Code		Number							
Address	Number					Street / Road																													
	Suburb / Town / City																				State			Postcode											
Can Dentist be contacted in emergency? Yes <input type="checkbox"/> No <input type="checkbox"/>																																			

Current History

Current medical problems

Regular medications including supplements, stating name and dosage

Allergies

Sports injuries (Please list any injury which is current/recurring or requires surgery)

Past History

Have you had ...

Epilepsy Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Heart Problems Yes ☐ No ☐
Heart Murmur Yes ☐ No ☐
Asthma/Bronchitis Yes ☐ No ☐
Hernia Yes ☐ No ☐
Concussion Yes ☐ No ☐

Do you wear ...

Glasses Yes ☐ No ☐
Contact Lenses
Soft Yes ☐ No ☐
Hard Yes ☐ No ☐
Protective Equipment Yes ☐ No ☐
Mouth Guard
at training Yes ☐ No ☐
at competition Yes ☐ No ☐
Other Yes ☐ No ☐

If yes, please specify

Have you sustained ...

A fracture in last 3 years Yes ☐ No ☐

If yes, where?

A dislocation Yes ☐ No ☐

If yes, where?

Do you suffer from ...

Recurring pain in any joint or muscle with play/practice? Yes ☐ No ☐

If yes, where?

Back / Neck pain Yes ☐ No ☐

Have you ever been treated for a head, neck or spinal injury? Yes ☐ No ☐

Details

Does this condition affect your performance?

*To the best of my knowledge, all information contained on this sheet is correct
(if under 18 please have parent or legal guardian sign)*

Signature

Date