

MOUNT ALLISON UNIVERSITY ATHLETIC DEPARTMENT - MEDICAL FORM

LAST NAME: _____ SPORT: _____

FIRST NAME: _____

BIRTH DATE: _____ (DAY/MONTH/YEAR)

HEALTH CARD # _____

PERMANENT ADDRESS: _____ PROVINCE: _____

PERMANENT PHONE NUMBER: _____

IN EMERGENCY NOTIFY: _____ RELATIONSHIP _____

PHONE NUMBER: Home: (_____) _____

Work: (_____) _____

FAMILY DOCTOR: _____ CITY: _____ PHONE NUMBER:(_____)

PART A: Please complete this form and bring it with you to your family physician's office

1. MEDICAL HISTORY

Check box if you have ever had or have now (check all that apply)

- | | | | | | |
|---------------------|--------------------------|-----------------------|--------------------------|------------------------------|--------------------------|
| Smoking Habit | <input type="checkbox"/> | Blurred/Double Vision | <input type="checkbox"/> | Infectious Mononucleosis | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | Recurrent Nosebleeds | <input type="checkbox"/> | Intestinal Disorder | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Collapsed Lungs | <input type="checkbox"/> | Hives, Rash, Skin Infections | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | Mental or Nervous Disorder | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Appendicitis | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> | Loss of Consciousness | <input type="checkbox"/> |
| Hernia | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | Cyst, Tumor, Growth | <input type="checkbox"/> |
| Recurrent Headaches | <input type="checkbox"/> | Stomach Ulcer | <input type="checkbox"/> | Bone & Joint Disease | <input type="checkbox"/> |
| Concussions | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |

Other (specify): _____

Please circle: YES or NO

- | | | |
|--|------------|-----------|
| Have you ever experienced heat exhaustion/heat stroke? | YES | NO |
| If so, were you hospitalized? | YES | NO |
| Have you ever experienced a fainting episode? | YES | NO |
| Have you ever had or have excessive urination or excessive thirst? | YES | NO |
| Have you ever had a blood transfusion? | YES | NO |
| On Average, how many alcoholic drinks do you consume weekly? | YES | NO |
| Do you use chewing tobacco? | YES | NO |

CURRENT MEDICATIONS (Including vitamins, supplements, and prescription drugs)

IMMUNIZATIONS: (Please provide year of last immunization, indicate if you do not know)

Tetanus: _____ Unknown: _____
 Rubella _____ Unknown: _____

MOUNT ALLISON UNIVERSITY ATHLETIC DEPARTMENT - MEDICAL FORM

NAME: _____
Print

ALLERGIES (List any allergies you have and describe what happens)

Environment _____
Medications _____
Others _____

VISION AND DENTAL HISTORY (Please circle)

Do you:

- | | | | | | |
|----------------------------------|------------|-----------|---------------|------------|-----------|
| 1 Wear glasses? | YES | NO | During Sport? | YES | NO |
| 2 Wear contacts? | YES | NO | During Sport? | YES | NO |
| 3 Have any other vision trouble? | YES | NO | | | |
| 4 Wear a mouth guard for sports? | YES | NO | | | |
| 5 Have denture / false teeth? | YES | NO | | | |

FAMILY HISTORY

Has any member of your family died suddenly during sports participation? **YES** **NO**

Has any member of your immediate family (Father, Mother, Sister, Brother) had any of the following illnesses? If the answer is yes please circle the illness

- | | | | | |
|-----------|---------|---------------|----------------|-----------------------|
| Diabetes | Goiter | Gout | Kidney Disease | Neurological Disorder |
| Allergy | Cancer | Tuberculosis | Mental Illness | High Blood Pressure |
| Arthritis | Obesity | Heart Disease | Blood Disorder | Sickle Cell Anemia |

ORTHOPAEDIC HISTORY Please answer every question in this section by circling YES or NO.

HAVE YOU EVER	YES	NO	NOTES- Doctor/Athletic Therapist/Physiotherapist /Self
1. Injured your head?	YES	NO	
2. Injured your neck?	YES	NO	
3 Injured your shoulder?	YES	NO	
4. Injured an elbow?	YES	NO	
5 Injured a wrist?	YES	NO	
6. Injured a hand?	YES	NO	
7 Injured a finger?	YES	NO	
8. Injured your abdomen?	YES	NO	
9 Injured a rib?	YES	NO	
10 Injured your back?	YES	NO	
11. Injured your hip?	YES	NO	
12. Injured a groin?	YES	NO	
13. Injured a quad and/or hamstring	YES	NO	
14. Injured a knee	YES	NO	

15. Injured a lower leg?	YES	NO	
16. Injured an ankle?	YES	NO	
17. Injured a foot?	YES	NO	
18. Had a serious muscle injury?	YES	NO	
19. Had orthopaedic surgery? If yes, do you have any pins, plates, or screws in your body?	YES	NO	
20. Been advised to have surgery which has not yet been done?	YES	NO	

*****HEAD INJURY HISTORY (CONCUSSIONS)*****

YEAR	SPORT	UNCONSCIOUS?	HOSPITALIZED?	NOTES?
#1.				
#2.				
#3.				

Release of Medical Information: I understand that any medical information relevant to my participation in athletic activities may be discussed with other physicians, therapists, trainers, and coaches.

ATHLETE'S NAME (PRINT)

ATHLETE'S SIGNATURE

DATE

PLEASE NOTE: We recommend that you purchase personal Health Insurance to make sure that you are covered for knee braces, ambulance bills, medications, etc. Mount Allison University does not cover or help subsidize these costs.

MOUNT ALLISON UNIVERSITY ATHLETIC DEPARTMENT - MEDICAL FORM

NAME: _____
Print

PART B: MEDICAL EXAMINATION

*****THIS PORTION IS TO BE COMPLETED BY YOUR FAMILY PHYSICIAN*****

NAME: _____ SPORT: _____
DATE (DD/MM/YYYY) ___ / ___ / _____

VISION: Left Eye _____ Right Eye _____
HEIGHT: _____ (Ft/in) WEIGHT: _____ (lb) PULSE: _____ (bpm)
BP: _____ BLOOD TYPE _____

	NORMAL	ABNORMAL	EXPLANATION
General Appearance			
Head and Neck			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurological (Reflexes)			
Integumentary			
LABORATORY DATA	NORMAL	ABNORMAL	EXPLANATION
***Urinalysis (Must be completed on ALL applicants)			
CBC (Where applicable)			
X-rays (Where applicable)			
OTHER			

MOUNT ALLISON UNIVERSITY ATHLETIC DEPARTMENT - MEDICAL FORM NAME: _____

Print

Please list any problems that may have been identified through the history, physical examination, and/or lab data:

MEDICAL CLEARANCE- PHYSICIAN TO COMPLETE
DATE:
<input type="checkbox"/> CLEARED TO PLAY- NO RESTRICTIONS
<input type="checkbox"/> CLEARED TO PLAY- WITH RESTRICTIONS
<input type="checkbox"/> DISQUALIFIED: _____ TEMPORARY OR _____ SEASON
<input type="checkbox"/> CLEARANCE DEFERRED PENDING FOLLOWING REFERRAL/INVESTIGATION
PHYSICIAN: (PRINT) _____ (SIGNATURE) _____
(DATE) _____

Physician Address and Phone Number:

() _____

ONCE COMPLETED PLEASE MAIL OR FAX TO:

ATTENTION ATHLETIC THERAPIST
DEPARTMENT OF PHYSICAL RECREATION AND ATHLETICS
MOUNT ALLISON UNIVERSITY
50 YORK ST.
SACKVILLE, NB E4L 1C8
PHONE: (506) 364-2401
FAX: (506) 364-2217

202-2197 promenade Riverside Drive, Ottawa, Ontario K1H 7X3 Canada
Tel./tél. 613.521.3340 Fax/Télé. 613.521.3134 InfoLine 1 800.672.7775
info@cces.ca www.cces.ca

Abbreviated Therapeutic Use Exemption Form

All applicable areas must be completed. Incomplete forms will be returned. Please print clearly.

1. Athlete Information

Last Name: First Name: (check) Male Female
Date of Birth (dd/mm/yy):/...../..... Sport: Discipline/ Position:
Street Address: City: Province: Postal Code:
Tel: Home : (.....) Work/School : (.....) Mobile: (.....) E-mail:
If athlete with a disability, indicate disability: National Sport Organization:

2. Medical Information

Diagnosis:
Medical examination/test performed:

Prohibited Substances Indicate <input checked="" type="checkbox"/> beside those that apply	Dose of Administration	Route of Administration	Frequency of Administration	Duration of this Medication Plan
<input type="checkbox"/> Formoterol (e.g. Oxeze Turbuhaler)		inhalation		
<input type="checkbox"/> Salbutamol (e.g. Ventolin Inhaler)		inhalation		
<input type="checkbox"/> Salmeterol (e.g. Serevent Inhaler)		inhalation		
<input type="checkbox"/> Terbutaline (e.g. Bricanyl Inhaler)		inhalation		
<input type="checkbox"/> Glucocorticosteroid please specify:				

Additional Information:

3. Physician's Information and Declaration

Name, qualifications and medical specialty: Fax: (.....)
Tel: Home: (.....) Work: (.....) Mobile: (.....) E-mail:
Address: City: Province: Postal Code:
I certify the above-mentioned substance/s for the above named athlete has been/are to be administered as the correct treatment for the above named medical condition. I further certify that the use of the alternative medications not on the World Anti-Doping Agency (WADA) Prohibited List would be unsatisfactory for the treatment of the above named medical condition. Specify reason:
Physician's signature: **Date:**/...../.....

4. Athlete's Declaration

I certify that the information under 1. is accurate and that I am requesting approval to use a substance or method from the WADA Prohibited List. I authorize the release of personal medical information to the CCES as well as to WADA staff and to the WADA Therapeutic Use Exemption Committee (TUEC) as well as to other Anti-Doping Organizations (ADO) under provisions of the World Anti-Doping Code. I understand that if I ever wish to revoke the right of the CCES or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.
Athlete's signature: **Date:**/...../.....
Parent/Guardian's signature: **Date:**/...../.....
(if the athlete is a minor, a parent or guardian shall also sign this form. If the athlete has a disability preventing him/her to sign this form, a parent or guardian shall sign together or on behalf of the athlete)

Abbreviated Therapeutic Use Exemptions are valid under the domestic doping control program for the duration of the treatment as prescribed by the physician up to a maximum of one year. Annual renewal is the athlete's responsibility to maintain.