UNIVERSITY OF ALBERTA Augustana Athletics

Returning Female Medical Form

2018-2019 Athletic Season

Varsity Team:_____

Year of Eligibility: 1 2 3 4 5
(Entering into)

Last Name:_____ First Name: _____

Local Address: _____ City: _____ Prov.:_____Postal Code: _____

Local Phone: ( )_____E-Mail:_____Age:_____

D.O.B.:_____ Student No.: _____ Prov. Health Care #:_____Prov: _____
Day Month Year

Emergency Contact (local): _____ Relationship:_____ Phone:_____

Emergency Contact (family): _____ Relationship:_____ Phone: _____

Medications: Please list all prescribed and over-the-counter medications and supplements you are currently taking:

_____

Do you have allergies? Yes ☐ No ☐ If yes, please specify your specific allergy:_____

WITHIN THE PAST YEAR… (Explain all "YES" answers in the space provided)

GENERAL QUESTIONS	Yes	No
1. Has a doctor denied or restricted your participation in sports for any reason? Please explain below.		
2. Have you been admitted to hospital for any reason?		
3. Have you had surgery? Identify surgeries below		
4. Have you been advised to be on any medication on a regular basis? Identify medications in space below		
5. Have you been advised to be on any supplements/vitamins on a regular basis. Identify below		
6. Have you had a skin infection? Identify below what infection and when		
7. Have you had any illness or medical condition lasting longer than one week?		
8. Have you had an injury requiring you to miss more than one practice or game?		
9. Have you had an injury requiring treatment/therapy?		
10. Do you currently have an incompletely healed injury?		
11. Have you had a concussion, or hit to the head causing confusion, headache, or memory problems?		
12. How many? When?		
13. Have you had numbness, tingling, or weakness in your arms or legs after a hit or a fall?		
14. Have you ever been tested for a blood-bourne pathogen? (ie HIV, Hep B or C). Please explain test results.		
15. Have you experienced coughing/wheezing with exercise?		
16. Have you experienced frequent or severe headaches?		
17. Have you got lightheaded, dizzy or felt more short of breath than expected during exercise?		
18. Has a doctor ever ordered testing for your heart? (including ECG, EKG, ultrasound, etc.)		

GENERAL QUESTIONS	Yes	No
19. Have you experienced heart palpitations (when you heart feels as if it is pounding/racing)		
20. Have you experience unexplained weight loss/gain?		
21. Have you been diagnosed with an eating disorder? (ie anorexia nervosa or bulimia nervosa)		
22. Have you been treated for anemia?		
23. Have you had any abnormality of menstrual cycle?		
24. Are you currently on birth control?		
25. Do you have questions regarding healthy ways to control your body weight?		
26. Is there anything else you wish to discuss with the U of A medical staff?		

Explain 'YES' answers

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Your pre-season medical will be collected and stored in a confidential manner at CCTR. Information pertaining to clearance and/or restrictions will be shared only with those in the school administration who need to know. By signing this form, you are giving us permission to share information from the CCTR and information that may arise during the next academic year that could impact sports participation with those essential to the process of evaluation and future participation. This will include members of the Varsity Health Team. Specific medical information will not be discussed with non-healthcare professionals, but final clearance or disqualification decisions may be reviewed with school officials. We will attempt to maintain your privacy the best that we can during the pre season screening and during the upcoming sports season.

Athlete Signature:_____Date:_____