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 ☐ F ☐ | Date of Birth | Age: Years | Height: Centimetres | Weight: Kilograms

Blood Group | Do you object to transfusions? Yes ☐ No ☐

Emergency Contact

Surname | Given Names

Home Phone: Area Code | Number

Mobile / Business Phone: Number

Relationship

Health Care Details

Medicare Number | Private Health Insurance Yes ☐ No ☐ Fund

Private Doctor | Telephone: Area Code | Number

Address: Number | Street / Road

Suburb / Town / City | State | Postcode

Can Doctor be contacted at all times? Yes ☐ No ☐

Private Dentist | Telephone: Area Code | Number

Address: Number | Street / Road

Suburb / Town / City | State | Postcode

Can Dentist be contacted in emergency? Yes ☐ No ☐

Ambulance Membership **Yes** ☐ **No** ☐ **Membership Number**

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 ☐
Hepatitis A	Yes ☐	No ☐
Hepatitis B	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 with play/practice? Yes ☐ No ☐

If yes, which joint?

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