



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		Business Phone	Area Code	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		Business Phone	Area Code	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
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?
Adislocation 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