Bolts High Performance Program Health Examination Form

THE FIRST PAGE AND TOP OF SECOND PAGE TO BE COMPLETED BY PARENT OR GUARDIAN. FORM MUST BE SIGNED AND DATED. (SEE PARENT'S AUTHORIZATION & PERMISSION TO TREAT)

Player Name:_____

Last First Middle Initial

Date of Birth_____ Age_____ M/F _____

Parent or Guardian_____

Phone: Day (_____)_____Evening (_____)_____Cell (____) _____

Home Address_____

Number Street Name City Province Postal Code

Emergency Contact:

1. Name_____Relationship to Player_____

Home #_____ Work #_____ Cell#_____

2. Name_____Relationship to Player_____

Home #_____ Work #_____Cell#_____

INSURANCE INFORMATION:

OHIP#_____Private Insurance Company:_____ Policy#:_____

HEALTH HISTORY: (Check if the participant has had any of the following – giving approximate dates where applicable.)

ILLNESSES:		**ALLERGIES:**
Ear Infections_____	Chicken Pox _____	Hay Fever _____
Asthma _____	Rheumatic Fever _____	Ivy Poisoning etc. _____
Seizures_____	Chest Pain passing	Insect Stings_____
Diabetes_____	out with exertion _____	Penicillin _____
Behavior_____	**Covid-19**_____	Other Drugs _____

Details of Above (frequency, severity, triggers) and include any additional medication or food allergies:

_____
_____
_____
_____

Operations or Serious Injuries
(Dates)_____

Chronic or Recurring
Illness_____

SUGGESTIONS FROM PARENTS:

_____

_____

IMMUNIZATION RECORD…MEMBERS CANNOT BE ACCEPTED WITHOUT THIS INFORMATION

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series _____ booster _____ Tetanus booster (**within the last 10 years)** _____

Polio IPV _____ booster _____ MMR _____

Hepatitis B _____ Varicella (chicken pox)_____

Other provincial or municipal examinations required if any)_____

MEDICATIONS BE TAKEN – to be completed and signed by a parent or legal guardian

_____takes NO medications on a routine basis. _____

(Player Name) INT

_____ takes medications as follows (attach additional pages if needed):

(Player Name)

Medication:	Dosage:	Times taken each day:	Reason for taking:

THIS MUST BE SIGNED FOR PLAYER TO BE OFFICIALLY ENROLLED IN THE BOLTS HIGH PERFORMANCE PROGRAM

PARENT AUTHORIZATION & PERMISSION TO TREAT: The health history as listed is correct and accurate to the best of my knowledge. The player named herein has permission to engage in all soccer related activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by Bolts High Performance's medical director to provide routine health care: to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Bolts High Performance's medical director to secure and administer treatment, including hospitalization, for the player named above.

Parent/Guardian
Signature_____Date_____

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel:

Ht_____ Wt_____ B.P._____

The applicant is under the care of a physician for the following conditions:

_____

(For Female Players) Has this person menstruated? **Y/N** If yes, is her menstrual history normal? **Y/N**

Special considerations_____

Recommendations and restrictions while playing_____

Known allergies_____

Special meal plans or diet restrictions_____

Medications to be administered (name, dosage, frequency if different from above)_____

Limitations or restriction on physical activities_____

_____

Additional information for Bolts High Performance health care personnel

_____

_____

I examined _____on _____.

In my opinion, he/she applicant can participate in all soccer related activities.

SIGNATURE OF LICENSED MEDICAL PERSONNEL_____