Gymnastics Canada Gymnastique

MEDICAL HISTORY (COMPLETE ONE PER ATHLETE)

FORM MUST BE FULLY COMPLETED

1. ATHLETE'S NAME: _____ DATE: _____

2. PARENT OR LEGAL GUARDIAN INFORMATION (COMPLETE THIS SECTION IF UNDER 18YRS.)

CONTACT NAME: _____ DAYTIME PHONE: _____

EVENING PHONE: _____ ALTERNATE PHONE: _____

3. EMERGENCY CONTACT INFORMATION (COMPLETE IF DIFFERENT FROM SECTION 2)

CONTACT NAME: _____ DAYTIME PHONE: _____

EVENING PHONE: _____ ALTERNATE PHONE: _____

4. FAMILY PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ PHONE: _____

5. MEDICAL INFORMATION

PROVINCIAL HEALTH CARD: _____
NUMBER PROVINCE

Local medical services are covered by the provincial health plans and will require a valid health card. Please bring your health card with you to the event or provide us with the information on this form and we will make sure that the medical clinic has it.

Please print clearly (if you have answered YES to any question, please state the diagnosis, treatment you have or are receiving and if you have been cleared to compete.)

MEDICAL HISTORY INFORMATION	YES / NO (CHECK)	IF ANSWERED YES, PLEASE DESCRIBE
Do you know of any health reason why you should not participate in any gymnastics event?	**YES** ☐ / ☐ **NO**	

MEDICAL HISTORY INFORMATION	YES / NO (CHECK)	IF ANSWERED YES, PLEASE DESCRIBE
In the last year, has a doctor ever denied or restricted you participation in sports for any reasons?	**YES** ☐ / ☐ **NO**	
Have you had any surgery in the last 12 motnhs?	**YES** ☐ / ☐ **NO**	
Have you been diagnosed with a fracture, stress fracture or other bone injury in the last 12 months?	**YES** ☐ / ☐ **NO**	
Have you had any of the following injuries or conditions; Head injury /concussion	**YES** ☐ / ☐ **NO**	
Neck or back injury	**YES** ☐ / ☐ **NO**	
Trauma or overuse to any joint/bone	**YES** ☐ / ☐ **NO**	
Trauma or overuse to any ligament/tendon	**YES** ☐ / ☐ **NO**	
Asthma/breathing problems	**YES** ☐ / ☐ **NO**	
Bleeding or blood disorder	**YES** ☐ / ☐ **NO**	
Diabetes Heart disease	**YES** ☐ / ☐ **NO**	
History of seizures/ epilepsy	**YES** ☐ / ☐ **NO**	
Mononucleosis	**YES** ☐ / ☐ **NO**	
Infectious diseases (organs, bones etc.)	**YES** ☐ / ☐ **NO**	
Skin conditions including infection	**YES** ☐ / ☐ **NO**	
Other	**YES** ☐ / ☐ **NO**	
Are you currently taking any medication? Please list -	**YES** ☐ / ☐ **NO**	- - - - -
Are you currently wearing any type of protective equipment, bracing or taping for any existing injury or condition?	**YES** ☐ / ☐ **NO**	
Do you have any allergies? Please describe the severity -	**YES** ☐ / ☐ **NO**	

MEDICAL HISTORY INFORMATION	YES / NO (CHECK)	IF ANSWERED YES, PLEASE DESCRIBE
Do you carry and EPI pen?	**YES** ☐ / ☐ **NO**	
Do you wear eye glasses or contact lenses?	**YES** ☐ / ☐ **NO**	
Do you wear dental appliances?	**YES** ☐ / ☐ **NO**	
Do you have any significant family medical history?	**YES** ☐ / ☐ **NO**	

COMMENTS:

MEDICAL WAIVER

I, _____(the undersgined), hereby agree that the relationship between myself and any attending physician, therapist or allied medical personnel in connection with the event shall be governed by and constructed in accordance with the laws of the province in which the event is being held.
I _____ (the undersigned), state that, to the best of my knowledge, all of the answers on the preceding Medical History form are correct.

_____
Signature of Athlete

_____
Signature of Parent/Guardian (if athlete is under 18 years of age)