



# USA HOCKEY

## Medical History Form

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Birth date \_\_\_\_\_  
 \_\_\_\_\_  
 Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

### WHO TO CONTACT IN CASE OF EMERGENCY?

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
 Physician's Name \_\_\_\_\_  
 Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
 Hospital of Choice \_\_\_\_\_

### PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following?

	Circle One	
Head injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsion& epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No
specify: _____	Yes	No
Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other: _____	Yes	No
Impaired vision	Yes	No
Impaired hearing	Yes	No
Other: _____	Yes	No

Have you had a recent booster? \_\_\_\_\_ If so, when? \_\_\_\_\_

Are you currently taking Medications? \_\_\_\_\_ What? Why? \_\_\_\_\_

Has a doctor placed any restrictions on your activity? \_\_\_\_\_ Explain \_\_\_\_\_

Signed: (Athlete) \_\_\_\_\_ Date \_\_\_\_\_

Signed: (Parent) \_\_\_\_\_ Date \_\_\_\_\_