



English Ice Hockey Association Medical Department



Medical screening questionnaire

Name:	
Date of Birth:	
Address:	
Telephone number	
Doctors name and surgery	
Surgery Telephone	

If you are not registered with a doctor – please state this on the form

Emergency contact information

Name		
Relationship:		
Telephone:		

Medical History

	Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
1	Illness requiring medical attention in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you under observation by a doctor for a reason?	<input type="checkbox"/>	<input type="checkbox"/>
3	ECG's in the past/History of abnormal ECG?	<input type="checkbox"/>	<input type="checkbox"/>
4	Heart murmur or irregular or extra heart beats?	<input type="checkbox"/>	<input type="checkbox"/>
5	Have you ever had any chest pains, dizziness, shortness of breath, excessive fatigue during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6	Do you suffer from any Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
7	Are you able to have a Blood Transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
8	Are you taking any Medication?	<input type="checkbox"/>	<input type="checkbox"/>
	Details:		

Medical History Cont

9	Have you ever fainted or lost consciousness during exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
10	Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
11	High or low blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
12	Asthma/exercise induced asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
13	Loss or problem with any paired organs (eg eye, testicles kidneys)	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
14	Has anyone in your family suffered from high blood pressure, sudden death, heart attack or any hereditary Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> NO

Head Injury

1	Have you ever had a concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
2	If yes how many		
3	When was your last concussion		
4	Have you ever lost consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
5	If Yes for How long		
6	Have you ever been kept out of sport with a concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> NO

Please explain if yes was answered to any of these questions

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Allergic Reactions in detail

1	Do you have any allergies? (eg Stings, bites, food)	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
2	If yes what are you allergic to and what reaction do you develop?		
3	Do you carry an epi-pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO

I have read and fully understand this entire form. I have answered the questions thoroughly and accurately. I understand that it is my responsibility to inform the age group manager of any changes to the contents of this medical form.

Signed:.....

Date:.....

Signature of parent/guardian (Under18).....

Date

N.B. a Parent or Guardian should accompany a player to ALL fixtures, either at Home or Away, and should be available during training periods. If it is not possible for a player to be accompanied by a parent or Guardian, it is the parents responsibility to ensure that the manager or other club official is aware of the adult to whom parental responsibility has been transferred for the trip or training session