

# 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
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?   
A dislocation 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