

## 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					Weight					Kilograms				
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 <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis A	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma/Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you wear ...

Glasses	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Contact Lenses		
Soft	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hard	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Protective Equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mouth Guard		
at training	Yes <input type="checkbox"/>	No <input type="checkbox"/>
at competition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, please specify

Have you sustained ...

A fracture in last 3 years Yes ☐ No ☐

If yes, where?

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