

University of Prince Edward Island Panthers
Returning Student-Athlete
Medical History/Assumption of Risk/Consent to Receive Medical Care

Name: _____ **Student #:** _____ **Date:** _____

Personal Health Number: _____ Family Doctor: _____

In event of an emergency, please notify: _____

Relationship to you: _____ Home phone: _____

Work phone: _____ Cell phone: _____

	YES	NO
Have you had any serious illness, disease, injury, operation, mental illness, accident, or any other significant medical condition during the past year (12 months)? If yes, please explain		
Did this medical condition or any other medical condition require surgery? If yes, please explain, including date and location		
Have you been hospitalized or examined by a physician (other than a physician while playing with UPEI last season) during the past year (12 months)? If yes, for what reason?		
Have you been out of Canada within the last three (3) months? If yes, give an explanation		
Have you had a concussion during the past year (12 months) that was not evaluated by our team physician? If yes, give an explanation, including dates and location.		
Have you had any immediate relative die suddenly in the past year (12 months)? If yes, what was the cause of death?		
During the past year (12 months) have you had any type of problem with tolerance to exercise? If yes, please give a brief explanation.		

Complete the chart below and give details to the right if you have sustained injuries during the last 12 months

	YES	NO	R	L
HEAD				
NECK				
SHOULDER				
ARM				
ELBOW				
FOREARM				
WRIST				
HAND				
FINGERS				
CHEST				
SPINE				
ABDOMEN				
PELVIS				
HIP				
THIGH				
KNEE				
LEG				
ANKLE				
FOOT				
TOES				

ALLERGIES: *Include description of your usual allergic reaction*

Allergic to: _____

Usual reaction: _____

Medications: _____

CURRENT MEDICATIONS: *List any medications (prescription and over the counter) that you are presently using, including frequency of use:* _____

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us:

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

PRINTED NAME OF ATHLETE: _____ **DATE:** _____
(First) (Middle) (Last)

SIGNATURE OF ATHLETE: _____

Assumption of Risk

I understand that although UPEI and its training team (Trainer, Physiotherapist, Coaching Staff and/or Team Physician) take all possible precautions to safeguard your health and safety, serious and potentially debilitating injuries can and do occur while participating in any activity. I know that it is extremely important that all student-athletes and parents should thus consider and be ever mindful of the risks that are involved in such competition. I feel comfortable with and accept these risks that are associated with athletic practice and competition.

Initial: _____

Consent to Receive Medical Care

I give authorization to the UPEI Training Team (Trainer, Physiotherapist, Coaching Staff and/or Team Physician) to evaluate and treat any injuries that occur during my athletic participation at UPEI (this includes immediate first aid and treatment, x-ray, physical exam, follow-up care, and rehabilitation). I understand that the UPEI Training Team has the authority to prevent me from further participation because of an injury and/or because of undue liability to UPEI.

Initial: _____