



Mount Mystics 2021-2022 | MSVU Athletics & Recreation Student Athlete Medical History Card

Please complete the first 4 pages and bring entire document to the doctor's office.

Athlete Information

Sport: _____

Name: _____
First Name
Middle Name
Last Name

Local Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Home Phone #: (____) _____ Cell #: (____) _____

MSVU Student ID#: _____ Age: _____ Birth date: _____ Sex: _____
Day
Month
Year

Health Card #: _____ Expiry: _____

Health Insurance Provider: _____ Policy #: _____

Family Doctor: _____ City: _____ Phone #: (____) ____-____

Parent(s)/Guardian(s) Name(s): _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Home Phone #: (____) _____ Work #: (____) _____ Cell #: (____) _____

In Emergency Notify: _____ Relationship: _____

Home Phone #: (____) _____ Work #: (____) _____ Cell #: (____) _____

Student Athlete History

1. HISTORY - Please complete this form: *Indicate with an X* if you have ever had or have now (check all that apply)

Smoking Habit	Bone & Joint Disease	Cyst, Tumor, Growth	Recurrent Headaches
Hepatitis	Cancer	Intestinal Disorder	Blurred/Double Vision
Diabetes	Night Sweats	Venereal Disease	Infectious Mononucleosis
Heart disease	Dizziness	Back Pain	Irregular Heart Beat
Asthma	Collapsed Lungs	Depression	Hives, Rash, Skin Infections
Epilepsy	Chest Pain	Heart Murmur	Mental or Nervous Disorder
Gout	Shortness of Breath	Stomach Ulcer	Loss of Consciousness
Appendicitis	Hernia	Jaundice	Recurrent Nosebleeds
Concussions	Other (please specify):		

INDICATE YES OR NO USING AN "X" IN THE APPROPRIATE COLUMN:

Question	Yes	No
Have you ever experienced heat exhaustion/heat stroke?		
If so, were you hospitalized?		
Have you ever experienced a fainting episode?		
Have you ever had or have excessive urination or excessive thirst?		
Have you ever had a blood transfusion?		
On Average, how many alcoholic drinks do you consume weekly?		
Do you use chewing tobacco?		

2. CURRENT MEDICATIONS (Including vitamins, supplements, and prescription drugs):

3. IMMUNIZATIONS: (Please provide year of last immunization, indicate if you do not know)

A. Tetanus: _____ Unknown: _____

B. Rubella _____ Unknown: _____

4. ALLERGIES: List any allergies you have and describe what happens:

Environmental: _____

Medical: _____

Others: _____

5. VISION AND DENTAL HISTORY (Please circle)

Question	Yes	No	Question	Yes	No
Wear glasses?			During Sport?		
Wear contacts?			During Sport?		
Have any other vision trouble?					
Wear a mouth guard for sports?					
Have dentures / false teeth?					

6. ORTHOPEDIC HISTORY - Please answer each question by indicating YES or NO in the correct column:

HAVE YOU EVER:	YES	NO	NOTES - Doctor/Athletic Therapist/Physiotherapist /Self
1. Injured your head?			
2. Injured your neck?			
3. Injured your shoulder?			
4. Injured an elbow?			
5. Injured a wrist?			
6. Injured a hand?			

Student Athlete History Continued (page 3)

Athlete Name:		Sport:	
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HAVE YOU EVER:	YES	NO	NOTES - Doctor/Athletic Therapist/Physiotherapist /Self
7. Injured a finger?			
8. Injured your abdomen?			
9. Injured a rib?			
10. Injured your back?			
11. Injured your hip?			
12. Injured a groin?			
13. Injured a quad and/or hamstring?			
14. Injured a knee?			
15. Injured lower leg?			
16. Injured an ankle?			
17. Injured a foot?			
18. Had a serious muscle injury?			
19. Had orthopaedic surgery?			
20. Do you have any pins, plates, or screws in your body?			
21. Been advised to have surgery that has not yet been done?			

7. *HEAD INJURY HISTORY (CONCUSSIONS)*****

YEAR	SPORT	UNCONSCIOUS?	HOSPITALIZED?	NOTES:

8. FAMILY HISTORY

Has any member of your family died suddenly during sports participation? Yes or No: _____
 if yes, explain: _____

Has any member of your immediate family (Father, Mother, Sister, Brother) had any of the following illnesses?
 If the answer is yes, please place a check mark by the illness:

Diabetes		Gout		Neurological Disorder	
Allergy		Tuberculosis		High Blood Pressure	
Arthritis		Heart Disease		Sickle Cell Anaemia	
Goiter		Kidney Disease		Other:	
Cancer		Mental Illness			
Obesity		Blood Disorder			

Athlete Name: _____ Sport: _____

IMPORTANT NOTE:

You must purchase personal Health Insurance to make sure that you are covered for knee braces, ambulance bills, medications, etc. Mount Saint Vincent University does not cover or help subsidize these costs.

- The MSVU Students' Union operates a health and dental plan available to full-time undergraduate students attending MSVU.
- This is included in your Student Fees.
- Students who already have health and/or dental coverage through another plan have the option of opting out of the MSVU plans.
- Opt-Outs must be completed prior to the set deadline to be granted reimbursement.
- Visit mountstudents.ca for complete details. Click the Health & Dental Plan icon

I acknowledge that I have read and understand the information regarding Health & Dental Plans (Print Name):

Signature: _____

Release of Medical Information

I understand that any medical information relevant to my participation in athletic activities may be discussed with other physicians, therapists, trainers, and coaches.

Athlete Name: _____

Signature: _____

Date: _____



Mount Mystics 2019-2020
MSVU Athletic Office – Student Athlete Medical Form

Medical Examination

Name: _____ (print) Sport: _____

Date of Birth (DD/MM/YYYY): _____

BP: _____ Pulse: _____

	NORMAL	ABNORMAL	EXPLANATION
General Appearance			
Head and Neck			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurological (Reflexes)			
Integumentary			
LABORATORY DATA	NORMAL	ABNORMAL	EXPLANATION
Urinalysis (Where applicable)			
CBC (Where applicable)			
X-rays (where applicable)			
Other			

Continued.....

Please list any problems that may have been identified through the history, physical examination, and/or lab data:

MEDICAL CLEARANCE – PHYSICIAN TO COMPLETE	
<i>Please select one of the following:</i>	
Cleared to Play – No restrictions	
Cleared to Play – With restrictions	
Disqualified: _____ Temporary OR _____ Season(s)	
Clearance deferred pending following referral/investigation	

Physician Information

Physician Name (print): _____

Signature: _____ Date: _____

Physician Address: _____

Physician Phone Number: (_____) _____

Once completed please mail, scan & email, fax or return in person to:

Mount Saint Vincent University
Athletics & Recreation Office
Attention: June Lumsden/Mark Forward
166 Bedford Highway
Rosaria Student Centre
Halifax, NS B3M 2J6

Fax: 902-457-1694
Phone: 902-457-6370 or 902-457-6462
Email: june.lumsden@msvu.ca