Mount Mystics 2020-2021 | 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):					

Student Athlete History Continued (page 2)

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:	

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	
Please select one of the following:	
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