



## Mission Minor Lacrosse Medical History Form

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Personal Health Number: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Emergency Contact (if parent unavailable) \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Record of Illness – State any illnesses, injuries or conditions, past or present that may affect or be affected by performance

Asthma      Diabetes      Heart Disease      Seizures

Other: \_\_\_\_\_

(Specify) Other problems, previous injuries or surgery

Headaches      Blackouts      Chest Pain      Fractures (list) \_\_\_\_\_

# of Concussions: \_\_\_\_\_ Date of Last Concussion: \_\_\_\_\_

Other: \_\_\_\_\_

Are corrective lenses required?    Yes      No

Immunization: Year of last tetanus shot: \_\_\_\_\_

List allergies and/or medications taken regularly: \_\_\_\_\_

Any other information that may be relevant: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_