AURORA TIGERS JR. A HOCKEY CLUB 2024 PROSPECT CAMP

Name: ____ Date of Birth: ____ / ____ / ____

Address: __________________________________City: ______________ Postal Code: __________

Phone: ____________________________ Email: _________________________________

Health Card #: _______________________________________ Version Code: __________

Health Card Expiry Date: _______________________________ Province: _______

EMERGENCY CONTACT INFO
Name:___________________________Relationship:____________________________

Phone #1:____________________________ Phone #2:______________________________

FAMILY HISTORY (Circle "yes" or "no". If "yes", please provide a brief explanation) Has any member of your immediate family (e.g., parents, grandparents, siblings) had:

1. Sudden death before the age of 50? No / Yes ____________________
2. Heart disease or high blood pressure? No / Yes ____________________
3. Other medical problems (e.g., diabetes, liver disease): No / Yes ____________________ RELAVANT MEDICAL HISTORY (Circle "yes" or "no". If "yes", please provide a brief explanation) Have you had any of the following conditions?
1. Heart murmur: No / Yes __________________________
2. Heart disease/ conditions: No / Yes __________________________
3. High blood pressure or high cholesterol: No / Yes __________________________
4. Diabetes: No / Yes __________________________
5. Asthma or other breathing problems: No / Yes __________________________
6. Epilepsy or Seizures: No / Yes __________________________
7. Heat exhaustion: No / Yes __________________________
8. Dizziness or fainting with exercise: No / Yes __________________________
9. Chest pain with exercise: No / Yes __________________________
10. Kidney problems: No / Yes ______________________________
11. Surgery or hospitalization in the past 5 years: No / Yes __________________________

12. Other medical problems / Conditions:
____

PREVIOUS INJURIES:

(Circle “Yes” or “No”. If “Yes”, please provide a brief explanation including approximate date of injury) Have you had an injury or recurrent pain in any of the following body parts?

1. Head: No / Yes ____
2. Neck: No / Yes ____
3. Back: No / Yes ____
4. Shoulder: No / Yes ____
5. Elbow/Forearm: No / Yes ____

6. Hand/Wrist: No / Yes ____ 7. Hip/Groin: No / Yes ____ 8. Knee/Leg: No / Yes ____ 9. Ankle/Foot: No / Yes ____ 10. Other: ____ MEDICATIONS AND ALLERGIES:

List any medications you are presently taking, including vitamins, supplements and non-prescription drugs: ____
____
____

List any allergies you have (e.g., medications/drugs, tape, insects, foods) and describe allergic reaction:
____
____
____

HEAD INJURY HISTORY

1. Have you ever experienced a concussion? If YES, when and how long were you out for (If multiple concussions, please list all)
____
____

2. Have you ever been ‘knocked out’? No / Yes, when ________________________________

OTHER INFORMATION Please indicate any other medical conditions or health concerns
____
____
____

CERTIFICATION AND CONSENT FOR DISCLOSURE AND USE OF INFORMATION HEREIN:

I, the undersigned, hereby certify that I have made a full and complete disclosure in answering the questions above.

Signature of Athlete (If under 18, signature of parents/guardian is also required):
____

Signature of Athlete Signature of parents/guardian (if applicable) Date: ___________________