**Medical Form**

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| **General Information**Name of student :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth : \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ D M YSex: M - F Age:\_\_\_\_\_\_\_\_ Home phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mailing Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yukon Medical Health NO#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**In case of emergency please contact:**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mailing Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any Family Doctor?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Mecical History**

It is important that the history be as complete as accurate as possible. Students should check off both previous and current medical problems including all previous surgery as well as any significant injuries, i.e. fractures.

Record of Illness Muscular/Skeleton Problems
EPILEPSY \_\_\_\_\_\_ CONCUSSION \_\_\_\_\_\_\_
DIABETES \_\_\_\_\_\_ NECK INJURY PROBLEMS \_\_\_\_\_\_\_
INFECTIOUS MONONUCLEOSIS \_\_\_\_\_\_ BACK INJURY PROBLEM \_\_\_\_\_\_\_
ASTHMA \_\_\_\_\_\_ CAST \_\_\_\_\_\_\_

THYROID DISORDER \_\_\_\_\_\_ DISLOCATED JOINT \_\_\_\_\_\_\_

KIDNEY DISEASE \_\_\_\_\_\_ SPRAIN \_\_\_\_\_\_\_

SKIN DISEASE \_\_\_\_\_\_ KNEE INJURY \_\_\_\_\_\_\_

BLEEDING \_\_\_\_\_\_ SHOULDER INJURY \_\_\_\_\_\_\_

HEART PROBLEM \_\_\_\_\_\_ TENDINITIS \_\_\_\_\_\_\_

FEMALE ONLY METAL PLATE, SCREW, PINS?

 MENSTRUAL PROBLEMS \_\_\_\_\_\_ IF SO WHERE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BREAST PROBLEMS \_\_\_\_\_\_ BRACE, SUPPORT REQD?

MALE ONLY – HERNIA \_\_\_\_\_\_ IF SO WHERE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Equal vision on both eyes?\_\_\_\_\_\_\_ Wear glasses?\_\_\_\_\_\_\_\_\_\_\_\_ Contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES : (List symptoms);

CURRENT MEDICATIONS : List all DOSAGE FREQUENCY PRESCRIPTION CONDITIONS

Signature of parent/Legal Guardian : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_