

Varsity Therapy Clinic

Medical Information and Informed Consent to Treatment Document

Name: _____ Sex: M ___ F ___

Student Number: _____

Local Address: _____

City: _____ Prov: _____ PC: _____

Local Phone: _____ Cell Phone: _____

Email Address: _____

DOB: _____ OHIP #: _____

If out of province : Province: _____ Health Insurance #: _____

Did you opt out of the student health insurance plan? Y ___ N ___

School: DC _____ UOIT _____

Program: _____ Year _____

Sport: _____

Position: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship: _____ Contact Number: _____

Alternate Contact Name: _____

Relationship: _____ Contact Number: _____

Please indicate as a YES or NO

Family Medical History

	Yes	No
Diabetes.....	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>
Unexplained death before age 50	<input type="radio"/>	<input type="radio"/>
Anemia/Bleeding	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Other Hereditary Disease	<input type="radio"/>	<input type="radio"/>

Personal Medical History (If Yes, give details below)

	Yes	No
Do you have any allergies?	<input type="radio"/>	<input type="radio"/>
Do you have diabetes?	<input type="radio"/>	<input type="radio"/>
Do you have asthma or another breathing disorder?	<input type="radio"/>	<input type="radio"/>
Are you currently taking any prescribed medications?	<input type="radio"/>	<input type="radio"/>
Do you have a physical, hearing or visual disability that requires accommodation?	<input type="radio"/>	<input type="radio"/>
Do you wear glasses/contact lenses in practice/competition?	<input type="radio"/>	<input type="radio"/>
Do you have braces/or dental appliances?	<input type="radio"/>	<input type="radio"/>

Details: _____

Have you sprained/strained, dislocated, fractured or had other injuries to any bone or joint?
(check all that apply)

Head Neck Shoulder Elbow Wrist Hand/Finger
Back Hip Thigh Knee Shin/Calf Foot/Toe

Details: _____

	Yes	No
Have you ever had a head injury/concussion?	<input type="radio"/>	<input type="radio"/>

Number of times: _____ Date of last injury: _____

After being hit, did you have memory loss, unconsciousness, required hospitalization, recurrent head-aches, or have seizures?

.....	<input type="radio"/>	<input type="radio"/>
Have you had a major weight gain/loss recently?	<input type="radio"/>	<input type="radio"/>
Do you take dietary supplements?	<input type="radio"/>	<input type="radio"/>
Do you take any vitamins/minerals?	<input type="radio"/>	<input type="radio"/>
Have you had a Meningitis vaccination?	<input type="radio"/>	<input type="radio"/>
Have you had a Hepatitis vaccination?	<input type="radio"/>	<input type="radio"/>

Details: _____

Female Athletes Only

	Yes	No
Are you on hormonal birth control?	<input type="radio"/>	<input type="radio"/>
Did you miss a menstrual period last year?	<input type="radio"/>	<input type="radio"/>
Have you ever been diagnosed with anemia/low iron?	<input type="radio"/>	<input type="radio"/>

INFORMED CONSENT

As a Varsity Team member,

- I consent to the care and treatment by the athletic therapy clinic staff, and those supervised by the athletic therapist (s) (as defined by C.A.T. scope of practice) to myself, both in the clinic and during on-field play.
- I am aware that my medical and /or fitness status may be disclosed by the varsity athletic therapist (s) to my coach, where required for my health care, and I give permission for this.
- I understand that if I choose to seek medical advice external to the varsity athletic therapy clinic, for an injury or medical "condition" and, the "injury/condition" affects with my ability to play, I do consent to being re-evaluated by the varsity athletic therapist before being cleared to return to play.
- I understand that in order to facilitate this re-evaluation process, it is my responsibility to provide the varsity athletic therapy clinic with any test results and/or images from the external source, regarding the "injury/condition".

If there is a discrepancy of opinion concerning return-to-play between an external clinician and the varsity athletic therapist, I understand that the varsity athletic therapists clinician's decision will prevail.

- I have been advised by the varsity athletic therapy clinic that an annual physical on myself is recommended , to determine health status and ability to play prior to participating in the team sport.
- I am aware that failure to keep a booked appointment with the athletic therapy clinic and/ or provide 1 hours notice of cancellation of appointment will result in a \$20.00 NO SHOW fee to be charged.

The varsity athletic therapy clinic staff members are bound by conditions of employment, law and ethics to safeguard my privacy and the confidentiality of my personal information collected. Information will be disclosed to third parties only with my signed, written consent or when legally required.

Signature: _____ Date: _____

Printed Name: _____