

GB Para Ice Hockey Athlete Medical Form



Personal Details		
Full Name		
Address <i>(inc Postcode)</i>		
Date of Birth		
Phone Number		
Alternative Number		
Emergency Contacts		
Name	Phone No.	Relationship

GP Details		
Name of Surgery	Phone No.	Address

Medical Diagnosis Described/Defined as	Please describe your range and region of any impairment and where you have limited and/or loss of function. Please provide as much detail as possible.
Diagnosis	
Acquired Injury	Yes / No – If YES, year acquired:

PART A: Personal Health History	Please answer each question
Do you take any medication, inc supplements etc.	Yes / No Details:
Do you have any allergies	Yes / No Details:
Any previous history of concussions. If yes, please provide dates	Yes / No Details:

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PART B: Personal Health History		
<i>Circle Yes or No. If 'YES' please add more details in the box provided.</i>		
Fainting or Seizure during or after physical activity	YES	NO
Do you have an active Shunt (with hydrocephalus)	YES	NO
Near Fainting or Blackouts	YES	NO
Are you immunocompromised	YES	NO
Seizure and/or Epilepsy	YES	NO
Do you wear glasses (for more than just reading) If yes, are your lenses shatterproof	YES	NO
Do you wear contact lenses	YES	NO
Do you have any removable dental appliances	YES	NO
Do you have the need to carry an Epi-Pen	YES	NO
Do you have any hearing difficulties	YES	NO
Do you have Asthma or other respiratory related conditions	YES	NO
Do you ever have trouble breathing during exercise	YES	NO
Has there ever been a family history of unexpected death during physical activity or unexplained death of a young person	YES	NO
Do you have any heart conditions	YES	NO
Do you suffer from palpitations or racing heart	YES	NO
Do you have autonomic dysreflexia associated with high SCI	YES	NO
Do you have any family history of heart conditions	YES	NO
Do you have any blood disorders	YES	NO
Have you ever tested positive for Hepatitis	YES	NO
Do you have Diabetes (If yes, state Type 1 or Type 2)	YES	NO
Do you have difficulty controlling bladder or bowel/use catheters or have a stoma	YES	NO
Do you get irregular numbness or tingling in arms/legs/hands/feet	YES	NO
Do you have burner or stinger sensations such as from a pinched nerve, or pain in nek, back, shoulders, arms, hands, buttocks, legs or feet	YES	NO
Do you have or experience muscle spasticity or tightness	YES	NO
Do you have or experience paralysis (even if only temporary)	YES	NO
Do you wear a medical information bracelet/necklace	YES	NO
Do you have health problems that would interfere with participation in a hockey team	YES	NO
Have you had any illness that lasted more than a week and required medical attention in the last year	YES	NO
Have you had injuries requiring medical attention in the past year	YES	NO
Have you been admitted to hospital in the last year	YES	NO
Have you undergone surgery in the last year	YES	NO
Do you currently have any injured body parts	YES	NO
Do you have any vaccines NOT up to date (ie. Hep B, Tetanus)	YES	NO

Where you answered YES above, please enter more details below.

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Please list all current prescribed medication you are taking.

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NOTE:

Please understand during tournaments if you become unwell or injured team staff will ensure you are taken care of and or diverted to appropriate care givers, place of safety.

Unfortunately, they will not always be able to be with you 24/7 as they may need to be with the rest of the team. They will check up on you as regularly as possible and endeavour to help you in any way they can. You will not be left to your own devices.

If for any reason you have to remain after the rest of the team have returned home, we can't promise that anyone can stay with you. In such an instance we would contact your insurance company and your Emergency contact to come out to assist you.

We would encourage you to have a relative on standby to be able to join you if wanted or required.

Athlete Declaration

I have read and fully understand this entire form. I have answered the questions thoroughly, accurately, and honestly.

I understand it is my responsibility to inform the medical team of any changes to my medical condition or this form.

I give permission for this form to be passed to medical professionals in the event of a health issue/injury whilst with the GB National programme.

I understand that this form will be kept securely by the British Para Ice Hockey Association until:

- I leave the GB National programme, -or-
- Revoke my consent to the information being stored,

at which point it will be securely destroyed.

SIGNED:

Print Name:

Date:

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