TRIALIST MEDICAL FORM

Players name .....

Age group ..... Date of Birth .....

Home Address .....

..... Post Code .....

Telephone(s) .....

Mobile Number(s) .....

GP name .....

GP´s address ..... GP Telephone Number .....

Postcode .....

Current Club .....

Previus Clubs .....

How many games have you played in the last 12 months: .....

Have you undergone a Cardiac Screening assessment? .....

If so when .....

What club hold your medical records .....

List two people to contact in case of emergency:

Contact 1	Contact 2 .....
Name	Name .....
Adress	Adress .....
Tel numbers	Tel numbers .....

I hereby consent to have any assessment or treatment performed by the Club Doctor / Doctor / Physiotherapist / Sports Therapist employed by Deportivo Alavés.

Signature: ..... Date: .....

HEALTH RECORD

Please fill in the questionnaire below, which identifies any health related problems that you might have. We require this information to ensure that any health conditions you have identified are allowed for. Also, this will enable us to identify any additional equipment or support required for you.

Have you or any other member of your family (1st Generation i.e. parent, brother or sister) had or been treated for any of the following medical conditions

Heart Condition incl sudden cardiac death ..... YES/NO
Hypertension or stroke ..... YES/NO
Vascular problems, varicose veins or deep vein thrombosis ..... YES/NO
Cancer or any blood disorders ..... YES/NO
Asthma ..... YES/NO
Diabetes ..... YES/NO
Rheumatism ..... YES/NO

If you answered YES to any of the above, please give further relevant information:

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Immunisation History

Have you been vaccinated for any of the following:

Tetanus ..... YES/NO Date .....
Polio ..... YES/NO Date .....
Diphtheria ..... YES/NO Date .....
Whopping Cough ..... YES/NO Date .....
BCG ..... YES/NO Date .....
Typhoid ..... YES/NO Date .....
Hepatitis A ..... YES/NO Date .....
Hepatitis B ..... YES/NO Date .....

Other please specify

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Signature ..... Date .....

Have you had any of the following:

Measles ..... YES/NO Date .....

Mumps ..... YES/NO Date .....

Chickenpox ..... YES/NO Date .....

Glandular fever ..... YES/NO Date .....

Signature ..... Date .....

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING:

Fits or fainting attacks ..... YES/NO

Stomach condition ..... YES/NO

Urinary condition ..... YES/NO

Chronic or recurrent cough ..... YES/NO

Skin conditions i.e. Eczema, Psoriasis, Dermatitis ..... YES/NO

Eye (visual condition) ..... YES/NO

Colour blindness ..... YES/NO

Deafness ..... YES/NO

Kidney condition ..... YES/NO

Vertigo ..... YES/NO

Epilepsy ..... YES/NO

Any regular medication requirement? ..... YES/NO

Allergies to food, medication? YES/NO

If you answered YES to any of the above, please give further relevant information: .....

INJURIES OR ACCIDENTS

Have you recently been in a hospital? ..... YES/NO

Broken bones or fracturesz ..... YES/NO

Past injuries lasting more than 4 weeks ..... YES/NO

Hernia ..... YES/NO

Injury or a physical impairment ..... YES/NO

Concussion within last 12 months? YES/NO

If you answered YES to any of the above, please give further relevant information .....

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Please provide details of any injury that required specialist consultation or an operation?

Do you have any dietary allergies or requirements (halal)?

Do you have any other medical condition not already mentioned?

Signature ..... Date .....