PRE-PARTICIPATION QUESTIONNAIRE

All information on this document is legally binding. Access to this document is limited.

Personal Details

Surname

Given Name(s)

Address — Street Address

Suburb / Town / City | State | Postcode

Home Phone — Area Code | Number

Business Phone — Area Code | Number

Sex M ☐ F ☐ Date of Birth

Emergency Contact

Surname

Given Name(s)

Home Phone — Area Code | Number

Business Phone — Area Code | Number

Relationship

Health Care Details

Medicare Number

Private Health Insurance — Yes ☐ No ☐ Fund

Private Doctor — Name

Telephone — Area Code | Number

Can Doctor be contacted at all times? Yes ☐ No ☐

If yes, after hours contact — Area Code | Number

Private Dentist — Name

Telephone — Area Code | Number

Can Dentist be contacted in emergency? Yes ☐ No ☐

If yes, after hours contact — Area Code | Number

Other Commitments

Do you participate in any other sports? Yes ☐ No ☐

If yes, please complete table below for each sport

Sport	Number of sessions per week	Approx. length of sessions

Do you attend other groups/activities (e.g. scouts, venturers, youth groups, etc)? Yes ☐ No ☐

If yes, please complete table below for each group/activity

Group/Activity	Number of sessions per week	Approx. length of sessions

Please list any other activities that you have a regular commitment to (e.g. part time work, music lessons, etc)

Activity	Number of sessions per week	Approx. length of sessions

Medical Details

Blood Group

Do you object to transfusions? Yes ☐ No ☐

Have you received medical clearance from your doctor for this season? Yes ☐ No ☐

Do you take any regular medications? Yes ☐ No ☐ If yes, please list

Have you had . . .

Epilepsy	Yes ☐	No ☐
Hepatitis A	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐
Hernia	Yes ☐	No ☐

Concussion

Have you ever had **concussion**? Yes ☐ No ☐

How many times?

Give approx. dates

Do you wear protective head gear? Yes ☐ No ☐

If yes, specify type

Vision

Do you wear:

Glasses	Yes ☐	No ☐
Hard contact lenses	Yes ☐	No ☐
Soft contact lenses	Yes ☐	No ☐

Teeth

Do you wear a mouthguard? Yes ☐ No ☐

If yes, specify type

Do you wear your mouthguard

at training	Yes ☐	No ☐
at competition	Yes ☐	No ☐

Asthma

Do you suffer from asthma? Yes ☐ No ☐

Do you take medication for asthma? Yes ☐ No ☐

If yes, specify

Do you bring your medication to training/competition? Yes ☐ No ☐

Vaccinations

Have you been vaccinated against:

Hepatitis A	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐
Tetanus	Yes ☐	No ☐
Other	Yes ☐	No ☐

If other, please specify

HIV Status (optional)

Allergies

Are you allergic to:

Tape	Yes ☐	No ☐
Ice	Yes ☐	No ☐
Medications	Yes ☐	No ☐

Please specify medications

List any other allergies you have:

Injury Details

Were you injured last season (or during the off season)? Yes ☐ No ☐

If yes, please list

Do you wear protective equipment? Yes ☐ No ☐

If yes, please list

Have you sustained a fracture in the last 3 years? Yes ☐ No ☐

If yes, please list

Have you sustained a dislocation in the last 3 years? Yes ☐ No ☐

If yes, please list

Are there any past injuries still effecting your performance (e.g. pain, stiffness)? Yes ☐ No ☐

If yes, please list

Do you require specific taping/padding for a previous injury? Yes ☐ No ☐

If yes, please specify

Have you ever had a head, neck or spinal injury? Yes ☐ No ☐

If yes, please give details

To the best of my knowledge, all information contained on this sheet is correct (if under 18 please have parent or legal guardian sign)

Signature

Date