Medical History

Chicago Blackhawks Special Hockey

Athlete's Name: _____

Address: _____ Sex: _____ Age: _____

Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone: _____

Emergency Contact Information:

Name: _____ Relationship to Athlete: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

Insurance Company Name: _____ Policy/Medicare #: _____

Physician's Name: _____ Phone: _____

Hospital of choice: _____

Health History:

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper. Have you had (or do you presently have) any of the following?

Condition	Yes	No	If yes, describe
Head injury (concussion, skull fracture)	☐	☐	_____
Fainting spells	☐	☐	_____
Convulsions/Epilepsy	☐	☐	_____
Neck or back injury	☐	☐	_____
Asthma	☐	☐	_____
High blood pressure	☐	☐	_____
Kidney problems	☐	☐	_____
Hernia	☐	☐	_____
Diabetes	☐	☐	_____
Heart Murmur	☐	☐	_____
Allergies (drugs, food, inhalants, etc.)	☐	☐	_____
Impaired vision	☐	☐	_____
Impaired hearing	☐	☐	_____

Diagnosis or disabling conditions which would prohibit you from playing in a mainstream hockey program:

_____

_____

Have you had a recent tetanus booster? ☐ Yes ☐ No If so, when? _____

Medications (Type, strength and dosage): _____

Reason for medication: _____

Does athlete have Down syndrome: ☐ ☐

If yes, please indicate date and result of x-ray for Atlanto-Axial Dislocation: _____

Results: ☐ Positive ☐ Negative

Note: *If the athlete has Down syndrome and has not had this x-ray, they must have one done in order to continue with the program.*

Has the doctor placed any restrictions on your activity? ☐ Yes ☐ No

Explain restriction(s): _____

_____

_____

Any special information that you would like us to know about the athlete and or your family:

_____

_____

_____

_____

In my opinion, there is no reason why the above-named individual should not participate in the Chicago Blackhawks Special Hockey program.

Physician's Signature: _____ Date: _____

Printed Name: _____

Physician's Address: _____

Physician's Phone Number: _____