



BCSPL mandatory league medical form-2023

First Name: _____	Address: _____
Last Name: _____	City: _____

Birthday (mm/dd/yy): _____	Postal Code: _____ Province: _____
Height: _____ Weight: _____	Care Card #: _____

Emergency Contact Information:

Contact 1: _____	Phone: _____	Cellular: _____
Contact 2: _____	Phone: _____	Cellular: _____

Family Physician: _____ Phone: _____

Medical and Illnesses History

Does your child have any of the following conditions or occurrences? If “yes,” please check or circle the item and comment further in the “details” area with any information that could be relevant in an emergency or accident situation:

Condition:	Details:
<u>Respiratory Concerns:</u> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Smoking <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other	
<u>Circulatory Concerns:</u> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Hypo/Hypertension <input type="checkbox"/> Heart Condition <input type="checkbox"/> Fainting <input type="checkbox"/> Other	
<u>Nervous Concerns:</u> <input type="checkbox"/> Neck Condition <input type="checkbox"/> Back Condition <input type="checkbox"/> Spinal Condition <input type="checkbox"/> Seizures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other	
<u>Head Concerns:</u> <input type="checkbox"/> Concussion <input type="checkbox"/> Ears / Hearing <input type="checkbox"/> Eyes / Eyesight <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Stroke <input type="checkbox"/> Glasses / Contacts	
<u>Musculoskeletal – Sprains, Strains, Fractures or Tears:</u> <input type="checkbox"/> Upper Body <input type="checkbox"/> Lower Body <input type="checkbox"/> Skin Condition <input type="checkbox"/> Dental <input type="checkbox"/> Other	
<u>Other Concerns or Conditions:</u> <input type="checkbox"/> Food Allergies <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Infections <input type="checkbox"/> Immune Conditions <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Thyroid <input type="checkbox"/> Kidney <input type="checkbox"/> Reproductive <input type="checkbox"/> Diabetes <input type="checkbox"/> Urinary <input type="checkbox"/> Menstrual <input type="checkbox"/> Liver <input type="checkbox"/> Ulcers <input type="checkbox"/> Other <input type="checkbox"/> Bowel <input type="checkbox"/> Pregnancy	

Use this area to expand on the details above and list any past surgeries, hospitalizations or other concerns we should be aware of.

Medications currently used and reason for using:	
Prescribed: _____	Non-Prescribed: _____
Signature of Parent / Guardian: _____	Date: _____

