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MEDICAL REPORT

	Y	N		Y	N
Have you had a medical illness or injury since your last check up or sport physical?			Have you ever had a head injury or concussion?		
Do you have an ongoing or chronic illness?			Have you ever been knocked out, become unconscious or lost your memory?		
Have you ever been hospitalized overnight?			Have you ever had a seizure?		
Have you ever had surgery?			Have you ever had numbness or tingling in your arms hands, legs, or feet?		
Are you currently taking any prescription or nonprescription medicaments or pills or using an inhaler?			Have you ever had a stinger, burner, or pinched nerve?		
Have you ever taken any supplements or vitamins to help your gain or lose weight or improve your performance?			Have you ever become ill from exercising in the heat?		
Do you have any allergies (to pollen, medicine, food or stinging insects)?			Do you cough, wheeze, or have trouble breathing during or after activity?		
Have you ever had a rash or hives develop during or after exercise?			Do you have asthma?		
Have you ever passed out during or after exercise?			Do you have seasonal allergies that require medical treatment?		
Have you ever been dizzy during or after exercise?			Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee brace, foot orthotics, hearing aid, etc)?		
Have you ever had chest pain during or after exercise?			Have you had any problems with your eyes or vision?		
Do you get tired more quickly than your friends do during exercise?			Do you wear glasses, contacts, or protective eye wear?		
Have you ever had racing of your heart or skipped heartbeats?			Have you ever had a sprain, train, or swelling after injury?		
Have you had high blood pressure or high cholesterol?			Have you broken or fractured any bones or dislocated any joints?		
Have you ever been told you have a heart murmur?			Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
Has any family member or relative died of heart problems or of sudden death before age 50?			Do you want to weigh more or less than you do now?	+	-
Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?			Do you lose weight regularly to meet weight requirements for your sport?		
Has a physician ever denied or restricted your participation in sports for any heart problems?			Do you feel stressed out?		

MEDICAL INSURANCE

Social Security number: _____

Other medical assurances: _____

Company: _____

Number of policy: _____



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VACCINE DOSES: ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN

	1	2	3	4	5
Diphtheria and Tetanus (DtaP, DTP, Td o DT)	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
Polio (OPV or IPV)	_/_/_	_/_/_	_/_/_	_/_/_	
Hepatitis B	_/_/_	_/_/_	_/_/_		
Measies- Mumps- Rubella (MMR)	_/_/_	_/_/_	Or Measles Serology: * Date _____ * Title _____ Rubella Serology: * Date _____ * Title _____		
Varicela (vaccine)	_/_/_	_/_/_			
Chicken Pox (disease)	Date _____				

• If your son needs a specific medication during his stay at the Academy, you must fill our the corresponding authorization form which can be requested from Canarias Basketball Academy
 • Should the situation arise where my son needs medical attention / hospitalization. I authorize the personnel of Canarias Basketball Academy to make the necessary medical consultations
 • Should it be necessary to provide my son with specific medication. I authorize the personnel of the Canarias Basketball Academy to administer it.

Date: _____
 Signed: _____

Medication Administered at Academy

Name: _____

Medication: _____

Dosage: _____

Comments: _____

Date: _____
 Signed: _____

Note: No medication will be administered without this form on file