



WRESTLING CANADA LUTTE

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Ottawa, Ontario
K1J 9E6 Canada

PRE-COMPETITION MEDICAL SCREENING

ATHLETE INFORMATION

Style: (please circle) FS GR FW Age Division: (please circle) SR JR JUV CAD

Name: _____ Date of Birth (dd/mm/yyyy): (/ / 19)

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Home Phone: () - _____

Emergency Contact: _____

Relation: _____ Phone: () - _____

MEDICAL INFORMATION

This information will be kept in confidence and will ONLY be released if required to deal with a medical situation concerning the health and well-being of the athlete.

Medical Card Number: _____

Taking Any Medication? YES: NO:

If YES, please specify: _____

Allergies (eg. Bee stings, prescription or non-prescription medications, food allergies, etc.): YES: NO:

If YES, please specify: _____

History of any previous head or neck injuries and/or concussions? YES: NO:

If YES, please specify: _____

Medical conditions (eg. Heart condition, epilepsy): YES: NO:

If YES, please specify: _____

Recent surgeries within the last 6 months: YES: NO:

If YES, please specify: _____

Do you have a known injury or medical condition that will need medical support (athletic/physiotherapy, massage therapy, chiropractic treatment, or physician) during the current competition? YES: NO:

If YES, please specify: _____

Signature of Athlete (REQUIRED)

Date

Signature of Parent/Guardian
(REQUIRED if athlete is under 18 years of age)

Date

