



"Home to Wushu
in Ontario"

WOS1- Sanda Athlete Medical Health Form

EFFECTIVE: 2010

WushuOntario 2370 Midland Ave, #B22, Scarborough, ON, M1S 5C6 416-321-5913 Fax: 416-321-5068, www.wushuontario.ca

WOS1-Sanda Athlete Medical Health Form

PART I - (To be completed by the athlete or by parent/guardian if under legal age of 18 in presence of Physician)

Name: _____
(First Name) (Last Name)
 Date of birth: ____/____/____ Gender: M____ F____ Weight: _____ Height: _____ (ft)____ (cm)
Mm/dd/yy
 Address _____ Postal Code: _____
 Telephone: _____ Club Name: _____
 OHIP Number: _____ Other (GMS, Blue Cross): _____

ATHLETE HEALTH INFORMATION	NO	YES	If YES, Please Comment
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal/Hepatic/GI Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous Surgical Procedures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever, T.B., Pleurisy or Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney or Urine Disorder, One Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion, Vomiting, Abdominal Cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acute Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures, Dislocations, Severe Sprains	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy, of Applicant or in Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any suspensions in combative sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____

EEG or MRI Results Enclosed Document / ECG Results Enclosed Document
 Blood Test Results [Hepatitis B, Hepatitis C, H.I.V.] Enclosed Document

Signatures
 Name of Parent/Guardian: _____ Signature: _____ Date: ____/____/____
Mm/dd/yy
 Athlete's Name: _____ Signature: _____ Date: ____/____/____
Mm/dd/yy



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PART II - (To be completed by the Physician at Consultation)

NOTE: The following may preclude from competing: (1) Impaired Vision – Worse eye less than 20/120 and better eye less than 20/60 (2) Squint (3) Recurrent Chronic Suppurative Otitis Media (4) Chest Expansion less than 2" (5) Total Deafness (6) Albuminuria (Hernia, Organomegaly or Undescended Testis (8) Heart Lesions.

Weight: _____ (lbs) _____ (kgs) Height: _____ (ft) _____ (cm) Expiration: _____ Inspiration: _____

Vision: Right Eye 20/_____ Left Eye 20/_____ Colour Vision: _____ Field of Vision: _____

Ears (State of T.M.S. and degree of deafness): _____

Teeth (Any braces): _____

Is there any abnormality in Chest, Heart, B.P. of C.N.S.?: _____

Is there a Hernia, Undescended Testis, Organomegaly, Cryptorchidism?: _____

Urinalysis (Labetix): Sugar _____ Protein _____ Blood _____

Chest X-Ray required only if there is a family history of T.B. _____

Blood Pressure B.P. _____ Pulse _____

Cardiovascular System-Normal Respiratory System-Normal

Abnormalities: _____

Additional for the FEMALE Athlete – NOTE: Confirmed pregnancy disqualifies from competing.

Are there Breast Lesions, Bleeding, Masses, Other Dysfunction, Pain? _____

Abnormality in Menstrual Pattern? Amenorrhea? _____

Lower Pelvic Pains? _____

ATHLETE IS HEALTHY AND PHYSICALLY FIT TO COMPETE IN A COMBATIVE FULL CONTACT SPORTING EVENT- YES NO

Physician's Signature of Approval

Physician's Name: _____

Address: _____

Telephone: _____

Physician's Signature: _____ Date: ____/____/____
Mm/dd/yy

For office use only

Date Received: ____/____/____ - Date Approved by VP Technical: ____/____/____