

Personal information			
Name			
Address			
Telephone		Mobile	
Email			
Date of birth			
Emergency contact			
Name			
Address			
Relationship to player			
Telephone		Mobile	

Medical History			
What is your disability		If cervical, what level(s)	
Date of onset?		Do you have normal sensation to touch/pain? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any unusual medical issues as a result of your disability? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please explain:			

Do you have any medical conditions or allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please list each condition and/or allergy, as well as any medication you take for them below.		

Conditions (asthma, diabetes, epilepsy, anaemia, haemophilia, etc)	Medications (tablets, inhalers, creams, etc. – please list drug names)	Frequency (twice daily, only with symptoms, etc)

Allergies (bee stings, food, etc.)	Medications (tablets, inhalers, creams, etc. – please list drug names)	Dose/Frequency

Injury history - list any injuries, when they happened, who treated you, and your current status				
Type of injury (concussion, infection, wound, etc)	Date (month/year)	Treatment received (therapy, medication, surgery, etc)	Who treated you (doctor, trainer, etc)	Current status (recovered, etc)

**All information provided on this form is considered to be private and confidential and will be treated as such**

**Health and fitness assessment**

What other sports and physical activities do you participate in?	
How many hours per week do you train?	
Have you played wheelchair rugby before?	
If yes, where and for how long?	
Height	
Weight	

**Cardiac questionnaire - Please check all that apply to you**

Fainting symptoms Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart palpitations Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizzy spells Yes <input type="checkbox"/> No <input type="checkbox"/>	Chest pain or tightness Yes <input type="checkbox"/> No <input type="checkbox"/>
History of high blood pressure Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>
History of Autonomic Dysreflexia (AD) Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke cigarettes Yes <input type="checkbox"/> No <input type="checkbox"/>
Has anyone in your family under 50 died from sudden death Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you suffer from breathlessness or get tired more easily than teammates? Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Additional notes and comments**

**Signatures**

Date of profile completion	
Athletes name	
Athletes signature	
Profiler's name	
Profiler's signature	
Follow up date (if applicable)	

Note: If a player is less than 18 years of age, the consent and signature of their legal guardian must be obtained before allowing them to actively participate in Wheelchair Rugby.