



Peterborough Thunder Volleyball Club Athlete Information

Personal Information

Name: _____ Health Card #: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Parent's Email: _____

Birth date (dd/mm/yyyy): _____ Ht: _____

Father: _____ Phone: w) _____ h) _____ c) _____

Mother: _____ Phone: w) _____ h) _____ c) _____

Emergency Contact: _____ Relationship: _____

Phone: w) _____ h) _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Volleyball Information

School: _____ Years Played: _____

Positions: _____ Coach: _____

Please Choose Appropriate Division:

- | | |
|---|---|
| <input type="checkbox"/> Girls Under 13 (born in 1996 or after) | <input type="checkbox"/> Girls Under 15 (born in 1994 or after) |
| <input type="checkbox"/> Girls Under 14 (born in 1995 or after) | <input type="checkbox"/> Girls Under 16 (born in 1993 or after) |
| <input type="checkbox"/> Boys Under 16 (born in 1993 or after) | <input type="checkbox"/> Girls Under 18 OVA (born in 1991/92) |

For Club Use Only (To Be Filled In By Coach)

<u>Height</u>	<u>Reach</u>	<u>Block Jump</u>	<u>Spike Jump</u>	<u>Line Touch</u>	<u>Shoe Size</u>



Peterborough Thunder Volleyball Club Athlete Information

Medical Information

This form is designed for you. The questionnaire helps identify athletes who should have medical consent before participating with PTVC. Read all the questions carefully and answer **YES** or **NO** opposite the appropriate question. Sign and date this form at the bottom after completing it in full.

YES NO

- 1. Has your doctor ever said you have a heart condition and recommended only medically approved physical activity?
- 2. Do you have chest pain brought on by physical activity?
- 3. (a) Have you ever been treated for a head injury?
- (b) In the last year?
- 4. Do you lose consciousness or lose your balance as a result of dizziness (i.e. Epilepsy)?
- 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity (i.e. Arthritis)?
- 6. Is your doctor currently prescribing medication for your blood pressure or heart condition (i.e. Diuretics or water pills)?
- 7. Significant present or past injury? Explain:
- 8. Chronic medical problems such as back or knee pain. Explain:
- 9. Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?

If you answered **YES** to #3B, you are required to see a physician before participating with PTVC. Talk to your Coach if you need assistance or clarification.

Do you wear any of the following:

Corrective Lenses: ____
 Contact Lenses: ____
 Dentures or Braces: ____
 Orthopedic Braces: ____

Do you suffer from any of the following:

Recurring Headaches: ____
 Blackouts: ____
 Seizures: ____
 Chest Pain: ____

Have you had a Tetanus Shot in the last ten years? _____

Have you had a measles shot in the last ten years? _____

I (print) _____ have read and answered the Peterborough Thunder Volleyball Club Medical Information Form (see above). I certify all my answers to be true and I declare myself in good health and ready to participate within PTVC.

Parent Signature: _____

Athlete Signature: _____ Date _____