

Medical Clearance Form RBIHF
Royal Belgium Icehockey Federation vzw
Season: 2009 - 2010



To be filled in by player (if necessary with aid of parents or family physician)

Name:		Date of birth:	
Club:		Nationality:	
Sex:		Phone:	
Marital Status:		E-mail:	
Address:		Profession:	
Postcode and city:			

History	Yes	No	Explain
Have you ever passed out during or after exercise ?			
Have you ever been dizzy during or after exercise ?			
Have you ever had chest pain during or after exercise ?			
Have you ever had racing of your heart or skipped hearbeats ?			
Have you had high blood pressure or high cholesterol ?			
Do you get tired more quickly than your friends do during exercise ?			
Have you ever been told you have a heart murmur ?			
Has any family member or relative died of heart problems or of sudden death before age 50 ?			
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month ?			
Do you have any allergies (for example, to pollen, medicine, food or stinging insects ?)			
Have you ever had a rash or hives develop during or after exercise ?			
Do you cough, wheeze or have trouble breathing during or after activity ?			
Do you have asthma ?			
Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler ?			
Do you have an ongoing or chronic illness ?			
Have you ever been hospitalized overnight ?			
Do you ever were unable to participate in your sport for longer time due to a medical problem ?			
Have you broken or fractured any bones or dislocated any joints ?			
Are you injured at this moment or recently ?			
Do you use any special protective or corrective equipment or devices during practice or game like a knee brace, foot orthotics or taping ?			
Are you regularly hindered during practice or game by physical complaints ?			
Have you ever had numbness or tingling in your arms, hands, legs or feet ?			
Did you ever take nutritional supplements or vitamins to influence your weight or performance ?			
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters ?)			
Have you ever had a head injury or concussion ?			
Have you ever been knocked out, become unconscious, or lost your memory ?			
Have you ever had a seizure ?			
Do you have frequent or severe headaches ?			
Have you ever become ill from exercising in the heat ?			
Have you had any problems with your eyes or vision ?			
Do you wear glasses, contacts or protective eyewear ?			
Do you feel stressed out, down, irritated or exhausted ?			
Date of last dental check-up:			

TO BE FILLED IN BY A PHYSICIAN

Athlete's name: _____

Date of birth: ___ / ___ / ___

Physical Examination:

Length (cm):	Weight (kg):
BP:	Pulse:
Vision R 20/ L 20/	Corrected Y/N Pupils Equal/Unequal

Normal: Abnormal findings:

Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Lungs		
Pulses		
Abdomen		
Genitalia (Males only)		
Skin		
Neuro		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

date: ... / ... / 20..

Signature of athlete:

I, undersigned, Dr. _____ declare that _____

0 cleared *

0 cleared after completing evaluation/rehabilitation for:*

0 NOT cleared for with reasons:*

Recommendations: _____

to play icehockey.

date: ... / ... / 20..

Signature of physician with address and phone:



Sent to:
 Dr. Jens Van Akeleyen
 President Medical Commission RBIHF
 Larikslaan 14
 B-2200 Herentals

* check what's correct