Date:

Player SAMPLE Form

Team Logo here

SAMPLE FORM PART A

PLAYERS DETAILS TO BE COMPLETED BY THE PLAYER / PLAYER'S PARENT OR GUARDIAN

PLAYERS NAME (as per NRIC / Passport)		DOB	AGE	GENDER
ADDRESS		NATIONALITY		
		ID / PASSPORT NO		
		MOBILE NO		

	NAME & DESIGNATION	MOBILE	EMAIL
EMERGENCY CONTACT (Next Of Kin)			

ALLERGIES (Food / Drug) Please Specify	

		DRUG NAME, DOSAGE & FREQUENCY	INDICATION/S
MEDICATIONS	1		
	2		

		DIAGNOSIS / CONDITION	TREATMENT	CURRENT STATUS
PAST MEDICAL HISTORY (Including Injuries, Medical Conditions and Concussions)	1			
	2			
	3			

Insurance Coverage (Type and Provider)		Policy Number	

(For players below 18 years of age.)

I, _____(Full name of Parent/Guardian) confirm the information provided above is accurate and up to date,_____(Signature & Date).

	BLOOD PRESSURE	PULSE RATE	HEART	LUNGS	VISUAL ACUITY	RIGHT	LEFT
BASELINE MEDICAL EXAMINATION (To Be Completed by the Team Medic / Physio)					WITH AID / WITHOUT AID ☐ ☐		

BASELINE SCAT 6 (To Be Completed by the Team Medic / Physio)	TEST DOMAIN	Date:	Date:	Date:
	Symptom Number (of 22)			
	Symptom Severity Score (of 132)			
	Orientation (of 5)			
	Immediate Memory (of 30)			
	Concentration (of 5)			
	Delayed Recall (of 10)			
	Cognitive Total Score (of 50)			
	mBESS Total Errors (of 30)			
	Tandem Gait Fastest Time			
	Dual Task Fastest Time			

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Date:

Player SAMPLE Form

Team Logo here

SAMPLE FORM PART B
(Injury Report)

DATE		TIME IN		TIME OUT	

NAME		DOB	AGE	GENDER
MOBILE NO		NATIONALITY		
TEAM		JERSEY NO		ID / PASSPORT NO	

EVENT OF INJURY / ILLNESS Including mechanism of injury		**L**AST MEALS OR DRINK PRIOR TO INJURY
SIGNS & SYMPTOMS Patient's complaint & presentation		

EXAMINATION FINDINGS	
DIAGNOSIS	
TREATMENT / INTERVENTION Including medication	

REFERRAL INDICATED?
Including referral to hospital

NO ☐ YES ☐

OBSERVATION

TIME	GCS	BP	HR	RR	OTHER	REMARKS
5 MIN						
15 MIN						
30 MIN						

	NAME	SIGNATURE	DATE & TIME
CONSENT FOR TREATMENT			

	NAME	SIGNATURE	DATE & TIME
MEDICAL PRACTITIONER			

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