Date: _____

Player SAMPLE Form

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		Vaccinated for Covid-19	Yes ☐ No ☐

	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 21 years of age.)

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

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

BASELINE SCAT 5 (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 15)			
	Immediate Memory (of 30)			
	Concentration (of 5)			
	Neurological Exam (Normal / Abnormal)			
	Balance Errors (of 30)			
	Delayed Recall (of 5)			
	Delayed Recall (of 10)			

Player SAMPLE Form

SAMPLE FORM PART B

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			
MEDICAL PRACTITIONER			