

The Southern Independent Conference
Officials Alliance - SICOA

2008 Collegiate Officials' Medical Information

PART 1: PERSONAL DETAILS

First Name	_____	Last Name	_____
Address	_____	Telephone Home:	_____
	_____	Mobile:	_____
	_____	Email	_____
Age	_____	Gender	Male / Female
Date of Birth	_____		

PART 2: NEXT OF KIN DETAILS (to be contacted in case of emergency)

First Name	_____	Family Name	_____
Address	_____	Telephone Home:	_____
	_____	(include area code) Work:	_____
	_____	Mobile:	_____
Email	_____	Relationship	_____

PART 3: ABOUT YOUR NORMAL MEDICAL TEAM

General Practitioner

First Name	_____	Last Name	_____
Address	_____	Telephone Home:	_____
	_____	(include area code) Work:	_____
Date of Last Exam	_____	Mobile:	_____

Therapist (Physio/Masseur) as applicable

First Name	_____	Last Name	_____
Address	_____	Telephone Home:	_____
	_____	(include area code) Work:	_____
Date of Last Visit		Mobile:	_____

Please list any current illnesses or injuries:

Please list any significant previous illnesses or injuries

Have you had, or do you have now, any of the following conditions?

OFFICIALS

(Please provide specifics if you answered yes)

	Yes	No	Unsure
1. Do you have asthma, chest tightness, wheezing, or coughing spells during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever passed out, become dizzy or had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a heart abnormality or murmur diagnosed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an abnormal heart rate, palpitations or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a physician ever denied or restricted your participation in sport for heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have any of your relatives ever had cardiomyopathy, Marfan's syndrome, long QT syndrome or significant heart arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Any family history of serious illness, heart disease, Marfans syndrome or sudden death at a young age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a history of concussion or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had surgery or required hospitalization? (dates and brief details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you have a history of deep venous thrombosis (DVT) or clots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever suffered from depression, major anxiety or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have a chronic illness or see a physician regularly for any particular problem? (e.g. diabetes, epilepsy, thyroid, bowel disorder, hepatitis B/C, HIV or AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Any allergies to any medication, insects, food or other agents? Please list.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any problems with your skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition:			
17. Do you follow any special diet? (e.g. vegetarian, weight loss, Pritikin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had a nutritional deficiency diagnosed (e.g. iron, Vit B12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications

Please list all medications that you are using, even if it were only occasionally. This includes all pills, creams, inhalers, and sprays, cough mixtures and other over the counter items from the supermarkets or chemists.

Medications:

	Name	Dose	Frequency of Use (e.g. daily)
1.			
2.			
3.			
4.			
5.			

Vaccinations: (please put dates if you have had any of the following)

Tetanus		Influenza	
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Consent:

- ✓ I agree to complete this form in order to assure the SICOA staff I am fit to train and officiate, and I am aware that this form needs to be received by SICOA not later than August 15, 2008
- ✓ I am aware that some information may require clarification or follow up with my treating doctor and physiotherapist, and agree to the release of relevant information to these people.
- ✓ I understand that the information contained in this form is otherwise confidential and can only be released with my consent. I attest that all information is truthful and accurate.

Signature: _____

Date: ___/___/___

Return completed medical forms to:

John Walters, Supervisor of Officials
SICOA
PO Box 47651
Tampa, Florida 33646