

INTERCOLLEGIATE REGISTRATION & MEDICAL FORM



Centennial College – Athletics & Recreation Department

PLAYER INFORMATION:

| | | |
|--|--|------------------------|
| Name | Gender Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Sport | Position | Campus Attending |
| Street Address | City/Town | Province |
| Home Phone | Cell # | Postal Code |
| Student Number | Email Address | Citizenship |
| Academic Program | Campus Attending | |
| Years you have participated at Centennial: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | | |
| Have you previously attended another College or University Yes <input type="checkbox"/> No <input type="checkbox"/> | Name of College/University | City |
| Did you play on the 'varsity team' at that institution? Yes <input type="checkbox"/> No <input type="checkbox"/> | What sport(s)? | Number of years played |

INFORMATION HISTORY PRIOR TO ATTENDING CENTENNIAL COLLEGE

| | |
|--|--------------|
| Significant Athletic Accomplishment(s) | |
| High School(s) Attended | Hometown |
| Next of Kin to notify in an emergency | Relationship |
| Contact Number(s) | |

REGISTRATION PROCESS:

1. Only fully completed Intercollegiate Registration and Medical forms are accepted. (No hand written forms)
- 2a) On-line: forwarded to athletics@centennialcollege.ca
- b) In Person: Athletics and Recreation Department in the Athletic and Wellness Centre
- c) Head Coach: Prior to the second practice
3. Only student athletes with fully completed forms are permitted to practice

SIGNATURE: _____ **DATE:** _____

NOTE: Student Athletes selected to participate on an Intercollegiate team are required to sign a Waiver and Consent Form before eligible to play in an OCAA competition.



MEDICAL FORM

Please complete the medical form. Information remains confidential and only used in medical situations in consultation with the Athletics & Recreation Department, coaching staff and Athletic Therapist.

| | | |
|----------------------------|--------|--------|
| Name | SPORT | |
| Date of Birth (DD/MM/YYYY) | Height | Weight |
| Doctor's name | OHIP # | |

Do you wear EYE GLASSES at any time to play sports?

Do you wear CONTACT LENSES at any time to play sports?

Are you currently taking any medication? Yes No If yes, specify

Are you allergic to any drugs, food, etc.? Yes No If yes, specify

Have you ever sustained a head injury? Yes No If yes, specify

Have you ever sustained a spinal injury? Yes No If yes, specify

Have you ever had surgery/operation? Yes No If yes, specify

Do you have any medical conditions that are made worse by, or cause distress during exercise? (e.g. asthma, chest pains, muscle cramps, etc.) Yes No If yes, specify

ARE YOU SUBJECT TO: epilepsy migraine or headaches asthma dizzy spells fainting
 ulcers eye or ear problems skin condition kidney lack sensation hernia
 anemia hay fever or hives heart problems cancer blood disorder diabetes
 mental disorder respiratory problem high blood pressure menstrual problems

If **YES**, please provide details
 Are you subject to any **OTHER CONDITIONS** not mentioned above?

Please indicate () if you have received any injury to any of the following areas?

head nose teeth ear neck thorax ribs
 sternum upper back acromion-clavicular joint lower back shoulder rotator cuff
 wrist upper arm elbow forearm hand thumb finger
 hip thigh knee lower leg ankle sternoclavicular
 patella foot toes achilles tendon

Other:

SIGNATURE: _____ **DATE:** _____

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