PRE-PARTICIPATION QUESTIONNAIRE

MARTIAL ARTS INDUSTRY ASSOCIATION
THE PEAK INDUSTRY BODY FOR MARTIAL ARTS IN AUSTRALIA

All information on this document is legally binding. Access to this document is limited.

Personal Details

Surname

Given Name(s)

Address
Street Address

Home Phone
Area Code
Number

Suburb / Town / City
State
Postcode

Business Phone
Area Code
Number

Sex M ☐ F ☐ Date of Birth

Emergency Contact

Surname

Given Name(s)

Home Phone
Area Code
Number

Business Phone
Area Code
Number

Relationship

Health Care Details

Medicare Number

Private Health Insurance Yes ☐ No ☐ Fund

Private Doctor
Name

Telephone
Area Code
Number

Can Doctor be contacted at all times? Yes ☐ No ☐

If yes, after hours contact
Area Code
Number

Private Dentist
Name

Telephone
Area Code
Number

Can Dentist be contacted in emergency? Yes ☐ No ☐

If yes, after hours contact
Area Code
Number

Other Commitments

Do you participate in any other sports? Yes ☐ No ☐

If yes, please complete table below for each sport

Sport	Number of sessions per week	Approx. length of sessions

Do you attend other groups/activities (e.g. scouts, venturers, youth groups, etc)? Yes ☐ No ☐

If yes, please complete table below for each group/activity

Group/Activity	Number of sessions per week	Approx. length of sessions

Please list any other activities that you have a regular commitment to (e.g. part time work, music lessons, etc)

Activity	Number of sessions per week	Approx. length of sessions

Medical Details

Blood Group ☐ Do you object to transfusions? Yes ☐ No ☐

Have you received medical clearance from your doctor for this season? Yes ☐ No ☐

Do you take any regular medications? Yes ☐ No ☐ If yes, please list

Have you had . . .

Epilepsy	Yes ☐	No ☐
Hepatitis A	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐
Hernia	Yes ☐	No ☐

Concussion

Have you ever had **concussion**? Yes ☐ No ☐

How many times?

Give approx. dates

Do you wear protective head gear? Yes ☐ No ☐

If yes, specify type

Vision

Do you wear:

Glasses	Yes ☐	No ☐
Hard contact lenses	Yes ☐	No ☐
Soft contact lenses	Yes ☐	No ☐

Teeth

Do you wear a mouthguard? Yes ☐ No ☐

If yes, specify type

Do you wear your mouthguard

at training	Yes ☐	No ☐
at competition	Yes ☐	No ☐

Asthma

Do you suffer from asthma? Yes ☐ No ☐

Do you take medication for asthma? Yes ☐ No ☐

If yes, specify

Do you bring your medication to training/competition? Yes ☐ No ☐

Vaccinations

Have you been vaccinated against:

Hepatitis A	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐
Tetanus	Yes ☐	No ☐
Other	Yes ☐	No ☐

If other, please specify

HIV Status (optional)

Allergies

Are you allergic to:

Tape	Yes ☐	No ☐
Ice	Yes ☐	No ☐
Medications	Yes ☐	No ☐

Please specify medications

List any other allergies you have:

Injury Details

Were you injured last season (or during the off season)? Yes ☐ No ☐

If yes, please list

Do you wear protective equipment? Yes ☐ No ☐

If yes, please list

Have you sustained a fracture in the last 3 years? Yes ☐ No ☐

If yes, please list

Have you sustained a dislocation in the last 3 years? Yes ☐ No ☐

If yes, please list

Are there any past injuries still effecting your performance (e.g. pain, stiffness)? Yes ☐ No ☐

If yes, please list

Do you require specific taping/padding for a previous injury? Yes ☐ No ☐

If yes, please specify

Have you ever had a head, neck or spinal injury? Yes ☐ No ☐

If yes, please give details

To the best of my knowledge, all information contained on this sheet is correct
(if under 18 please have parent or legal guardian sign)

Signature Date