**MANCHESTER RUGBY CLUB PLAYER PASSPORT**

|  |
| --- |
| PERSONAL DETAILS |

|  |  |
| --- | --- |
| **NAME** |  |
| **RFU ID** |  |
| **DATE OF BIRTH** |  |
| **CURRENT AGE GROUP** |  |
| **ADDRESS** |  |
| **CONTACT NUMBER** |  |
| **EMAIL** |  |

|  |
| --- |
| EMERGENCY CONTACT |

|  |  |
| --- | --- |
| **NAME 1** |  |
| RELATIONSHIP TO PLAYER |  |
| TELEPHONE |  |
| **NAME 2** |  |
| RELATIONSHIP TO PLAYER |  |
| TELEPHONE |  |

|  |
| --- |
| MEDICAL HISTORY |

RISK FACTORS: Concussion History

Have you EVER had a concussion, had your “bell rung", or had any of the symptoms below as a result of a head injury? Y N If yes, previous number

**0** 1 2 3 4 5 6+

What type of symptoms did you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you out of activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever lost consciousness as a result of a head injury? Y **N** If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized as a result of a head injury? Y **N** Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any imaging tests of your brain (CT, MRI, DTI, other)? Y **N** Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent concussion? \_\_\_\_\_\_\_\_\_

Additional Risk Factors: Personal History

Have you ever been diagnosed with:

Headache or migraines? Y **N**

Learning disability / dyslexia? Y **N**

ADD / ADHD Y **N**

Depression, anxiety or other psychiatric disorder? Y **N**

Seizure disorder? Y **N**

Do you have any medical conditions, disabilities or allergies

|  |  |  |
| --- | --- | --- |
| **Condition** | **Medication** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| CONCUSSION HISTORY |

|  |  |
| --- | --- |
| CONCUSSION 1 | Date |
|  | Time |

|  |
| --- |
| Cause of Injury |

Symptoms

|  |  |
| --- | --- |
| Headache / head pressure  Feeling slowed down  Nausea / vomiting  Sensitivity to noise  Neck pain  Sensitivity to light  Drowsiness  Visual problems /blurred vision  Balance problems  Sleeping more than usual  Dizziness  Sleeping less than usual | Fatigue / low energy  Trouble falling asleep  Confusion  Sadness  "Don't feel right"  Nervous or anxious  Feeling "in a fog"  Feeling more emotional  Difficulty remembering  Irritability  Difficulty concentrating  Numbness or tingling |

|  |  |
| --- | --- |
| Treatment Received |  |
| Who treated you |  |
| Current Status of Injury |  |

|  |
| --- |
| CONCUSSION HISTORY |

|  |  |
| --- | --- |
| CONCUSSION 2 | Date |
|  | Time |

|  |
| --- |
| Cause of Injury |

Symptoms

|  |  |
| --- | --- |
| Headache / head pressure  Feeling slowed down  Nausea / vomiting  Sensitivity to noise  Neck pain  Sensitivity to light  Drowsiness  Visual problems /blurred vision  Balance problems  Sleeping more than usual  Dizziness  Sleeping less than usual | Fatigue / low energy  Trouble falling asleep  Confusion  Sadness  "Don't feel right"  Nervous or anxious  Feeling "in a fog"  Feeling more emotional  Difficulty remembering  Irritability  Difficulty concentrating  Numbness or tingling |

|  |  |
| --- | --- |
| Treatment Received |  |
| Who treated you |  |
| Current Status of Injury |  |

|  |
| --- |
| CONCUSSION HISTORY |

|  |  |
| --- | --- |
| CONCUSSION 3 | Date |
|  | Time |

|  |
| --- |
| Cause of Injury |

Symptoms

|  |  |
| --- | --- |
| Headache / head pressure  Feeling slowed down  Nausea / vomiting  Sensitivity to noise  Neck pain  Sensitivity to light  Drowsiness  Visual problems /blurred vision  Balance problems  Sleeping more than usual  Dizziness  Sleeping less than usual | Fatigue / low energy  Trouble falling asleep  Confusion  Sadness  "Don't feel right"  Nervous or anxious  Feeling "in a fog"  Feeling more emotional  Difficulty remembering  Irritability  Difficulty concentrating  Numbness or tingling |

|  |  |
| --- | --- |
| Treatment Received |  |
| Who treated you |  |
| Current Status of Injury |  |