



ATHLETE SCREENING

Parents name: _____

Date: _____

Cell: _____

Email: _____

Athlete's Name: _____

Age: _____

DOB: _____

HEALTH YES NO

Physical?

If yes when: _____

Growth spurt?

If yes how long ago and how much : _____

Sports doctor?

Nutritionist?

Physiotherapist?

Mental training?

INJURIES

DESCRIPTIONS (sprain 1st 2nd 3rd degree, torn muscle / ligament, muscle pulled, dislocated, broken, surgery)

Ankle

R _____

L _____

Knee

R _____

L _____

Groin

R _____

L _____

Elbow

R _____

L _____

Lower back : _____

Concussion: diagnosis

Achilles

R _____

L _____

Hip

R _____

L _____

Shoulder

R _____

L _____

Wrist

R _____

L _____

treatment:

Other Notes _____



TRAINING

Most recent level competed: _____

Personal Goal : _____

Club affiliated to: _____

Number of weekly hours training past season: _____

VAULT	SKILLS COMPETED	SKILLS TRAINING
BARS		
BEAM		
FLOOR		