SOUTH AFRICAN FOOTBALL ASSOCIATION

PLAYER MEDICAL FORM

MYSAFA

I, the undersigned, hereby certify that I examined:

Player's First name(s) & Surname: _____

RSA ID number. _____ Passport Number _____

DOB: _____ Home ph: _____ Mobile ph: _____

Next of kin: _____ Contact details _____

MEDICAL HISTORY

Presenting complaint

Respiratory/eng: _____ Cardiovascular: _____

Gastrointestinal: _____ Musculoskeletal: _____

Central nervous system: _____

Past complaints

Respiratory: _____ Cardiovascular: _____

Gastrointestinal: _____ Musculoskeletal: _____

Central nervous system: _____

Previous surgical history: _____

Previous rehabilitation

Type of injury: _____

Details of rehabilitation (including duration): _____

If more than one injury/rehab, provide details below: _____

Current diagnosis, if any: _____

Current treatment/management (including surgery/rehab) _____

Routine medication taken (including supplements) _____

Andi-doping education | Yes | No |

Known allergies: _____

Travel vaccination history

Country last visited: _____

Consulted travel health practitioner/clinic?	Yes	No
Do you have a travel vaccination card?	Yes	No

Expiry date: _____

Family history

Family member suffered cardiac event before age 50	Yes	No

If yes, provide details: _____

Relation: _____ Age at event: _____ Nature of event: _____

Participation/competition history

Current club: _____ Country of club: _____

Position currently playing: _____

Matches played in last 12 mo: _____

Habits

Do you smoke?	Yes	No

If yes, amount per day / number of years: _____

Do you drink alcohol?	Yes	No

If yes, amount per day / number of years: _____

FOR FEMALES ONLY

Presenting complaint

Menarche: _____

LNMP 20: ___ / ___ : _____

Cycle/pattern: 14 days / 21 days / 28 days / other: _____

No. sanitary towels / day: _____ No. of days: _____

Associated symptoms: _____

Contraception method: _____ Last dose: _____

Medical examination

Weight: _____ Height: _____

Blood pressure: _____ Pulse (rate/rhythm): _____

Respiratory rate: _____ Temp: _____

ENT: _____

Cardiovascular system: _____

Respiratory system: _____

Abdomen: _____

Musculoskeletal examination

Shoulders: _____ Upper limbs: _____ Back: _____

Hips: _____ Thighs: _____ Knees: _____

Ankles: _____ Feet: _____

Urine dipsticks: _____

ECG: _____

Baseline concussion assessment (e.g. SCAT 5): _____

Cleared to play / Cleared to play but requires further assessment: _____

Declaration

I, _____ declare that the above-mentioned information is true.

PLAYER SIGNATURE _____

Date: _____

Witness: _____ Date: _____

Details of Medical Practitioner

Full name and surname: _____

Qualifications: _____

PR/MP No.: _____

Signature: _____

Date: _____