ISU Medical Form (To be completed Online)

https://www.isu.org/clean-sport/medical/isu-medical-form)

Home > Clean Sport & Medical > Medical > ISU Medical Form

Please report all injuries (go to Part I) and all illnesses (go to Part II)

One Form must be completed by the Skater's Medical Staff or Chief Medical Officer for each injured or ill Skater.
Any copies of conducted laboratory, radiological or medical examination for the injury/illness are to be sent to by separate E-mail at medical@isu.ch

REASON: (*) ○ Withdrawal from ISU Event ○ Reporting Injury

NAME OF THE EVENT: (*)

LOCATION: (*)

DISCIPLINE: (*) ☐ Single ☐ Pairs ☐ Ice Dance ☐ Synchronized ☐ Speed Skating ☐ Short Track

ATHLETE NATIONALITY: (*)

AGE: (*)

GENDER: (*) ○ Male ○ Female

I. INJURY

DIAGNOSTIC IMPRESSION: (*)

DATE OF INJURY: (*)

September - 2022 -

Su	Mo	Tu	We	Th	Fr	Sa
28	29	30	31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	1

CHARACTERISTICS OF INJURY: ☐ Acute (new onset) ☐ Recurrent (upon previous injury) ☐ Chronic

CIRCUMSTANCES: ☐ Practice/Training ☐ Competition ☐ Other (specify)

BODY PART: ☐ Face ☐ Head ☐ Neck ☐ Upper back ☐ Sternum/ribs ☐ Lower back ☐ Abdomen/pelvis/buttock ☐ Shoulder/clavicle/upper arm ☐ Elbow/forearm ☐ Wrist/hand/fingers ☐ Hip/groin ☐ Thigh ☐ Knee ☐ Lower leg/Achilles tendon ☐ Ankle/foot

TYPE OF INJURY: ☐ Concussion ☐ Fracture ☐ Stress fracture ☐ Dislocation, subluxation ☐ Lesion of meniscus or cartilage ☐ tendon rupture ☐ ligaments (sprain) ☐ Muscle strain/tear ☐ Contusion/bruise ☐ Chronic tendinopathy ☐ Arthritis/synovitis/bursitis ☐ Laceration/abrasion ☐ Nerve/Spinal chord ☐ Muscle cramsp/spasm ☐ Other (specify)

CAUSE: ☐ Contact with person ☐ Contact with equipment ☐ Contact with Boards/Pads ☐ Contact with Ice ☐ Non-contact injury

INJURY SEVERITY: ○ Resumed activity ○ Unable to train/compete ○ Transport to hospital

EXPECTED ABSENCE: ○ Less than 1 day ○ 1 to 3 days ○ 4 to 7 days ○ Greater than 7 days

II. ILLNESS

MAIN SYMPTOM(S): ☐ Fever ☐ Pain ☐ Diarrhea/vomiting ☐ Dyspnea/cough ☐ Palpitations ☐ Dehydration ☐ Itching/Skin rash ☐ Syncope/collapse ☐ Lethargy/dizziness ☐ Other (Specify)

AFFECTED SYSTEMS: ☐ Respiratory (ear, nose, throat) ☐ Gastro-intestinal ☐ Cardio-vascular ☐ Allergic/immunological ☐ Neurologic/psychiatric ☐ Dermatologic ☐ Dental ☐ Other (Specify)

SUPPOSED CAUSE OF ILLNESS: ☐ Pre-existing (e.g. asthma, allergy) ☐ Infection ☐ Exercise-induced ☐ Environmental ☐ Other

TREATMENT

TREATMENT MODALITIES: (*) ☐ Ice ☐ Heat ☐ Taping ☐ Rest ☐ Massage ☐ Ultrasound ☐ Medication ☐ Manual therapy ☐ Immobilization ☐ Muscle stimulation ☐ Suture/Wound care ☐ Other (specify)

MEDICATION #1:

MEDICATION #2:

MEDICATION #3:

MEDICATION #4:

FULL NAME: (*)

FUNCTION/TITLE: (*) (Please Select...)

E-MAIL (*)

TERMS AND CONDITIONS (*) ☐ I declare that these information are correct

SECURITY (*)

SUBMIT RESET

July 2019 - Medical Information Package (#9)