PLAYER MEDICAL INFORMATION SHEET

Name: _____

Address: _____

City / Province: _____ Postal Code: _____

Telephone: ( ) _____

Date of Birth: Day: _____ Month: _____ Year: _____

Provincial Health #: _____

Mother's Name _____ Home Phone: ( ) _____

Work Phone: ( ) _____

Father's Name _____ Home Phone: ( ) _____

Work Phone: ( ) _____

Person to contact in case of accident or emergency, if parents are not available:

Name: _____ Phone: ( ) _____

Address: _____

Doctor's Name: _____ Phone: ( ) _____

Dentist's Name: _____ Phone: ( ) _____

Please check the appropriate response below pertaining to your child:

YES	NO		YES	NO	
☐	☐	Previous history of concussions	☐	☐	Diabetic
☐	☐	Fainting episodes during exercise	☐	☐	Medication
☐	☐	Epileptic	☐	☐	Allergies
☐	☐	Wears glasses	☐	☐	Wears a medic alert bracelet or necklace
☐	☐	Are lenses shatterproof?	☐	☐	Surgery in the last year
☐	☐	Wears contact lenses	☐	☐	Has been in hospital in last year
☐	☐	Wears dental appliance	☐	☐	Presently injured
☐	☐	Hearing problem	☐	☐	Has had injuries requiring medical attention in the past year
☐	☐	Asthma	☐	☐	Has had an illness lasting more than a week in the past year
☐	☐	Trouble breathing during exercise	☐	☐	Has a health problem that would interfere with participation on a hockey team
☐	☐	Heart condition			

Please give details below if you answered "Yes" to any of the above items. Use separate sheet if necessary.

_____

_____

_____

_____

Medications:

Allergies:

Medical Conditions:

Recent Injuries:

Last Tetanus Shot:

Date of last complete physical exam:

Any information not covered above:

Any medical condition or injury problem should be checked by your physician before participating in a hockey program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take my child to hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Parent of Guardian: _____