

## 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	
<input type="checkbox"/>	<input type="checkbox"/>		Previous history of concussions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic
<input type="checkbox"/>	<input type="checkbox"/>		Fainting episodes during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Medication
<input type="checkbox"/>	<input type="checkbox"/>		Epileptic	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>		Wears glasses	<input type="checkbox"/>	<input type="checkbox"/>	Wears a medic alert bracelet or necklace
<input type="checkbox"/>	<input type="checkbox"/>		Are lenses shatterproof?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery in the last year
<input type="checkbox"/>	<input type="checkbox"/>		Wears contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Has been in hospital in last year
<input type="checkbox"/>	<input type="checkbox"/>		Wears dental appliance	<input type="checkbox"/>	<input type="checkbox"/>	Presently injured
<input type="checkbox"/>	<input type="checkbox"/>		Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>	Has had injuries requiring medical attention in the past year
<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Has had an illness lasting more than a week in the past year
<input type="checkbox"/>	<input type="checkbox"/>		Trouble breathing during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Has a health problem that would interfere with participation on a hockey team
<input type="checkbox"/>	<input type="checkbox"/>		Heart condition			

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications:

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Allergies:

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Medical Conditions:

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Recent Injuries:

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Last Tetanus Shot:

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Date of last complete physical exam:

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Any information not covered above:

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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: \_\_\_\_\_

