PLAYER MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: _____

Provincial Health Number: _____

Mother's Name: _____ Father's Name: _____

Business Telephone Numbers: Mother _____ Father _____

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

Name: _____ Telephone: _____

Address: _____

Doctor's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

Please circle the appropriate response below pertaining to you child

Yes	No	Previous history of concussions
Yes	No	Fainting episodes during exercise
Yes	No	Epileptic
Yes	No	Wears glasses
Yes	No	Are lenses shatterproof?
Yes	No	Wears contact lenses
Yes	No	Wears dental appliance
Yes	No	Hearing problem
Yes	No	Asthma
Yes	No	Trouble breathing during exercise
Yes	No	Heart Condition
Yes	No	Diabetic
Yes	No	Has had an illness lasting more than a week in the past year
Yes	No	Medication
Yes	No	Allergies

Yes	No	Wears a medic alert bracelet or necklace.
Yes	No	Does your child have any health problem that would interfere with participation on a hockey team?
Yes	No	Surgery in the last year.
Yes	No	Has been in hospital in the last year.
Yes	No	Has had injuries requiring medical attention in the past year.
Yes	No	Presently injured.

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: _____

Any information not covered above: _____

_____

Date of last complete physical examination: _____

* 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 or Guardian: _____