PLAYER MEDICAL INFORMATION SHEET

Name: ____

Date of birth: Day ________ Month __________ Year _________

Address: ____

Postal Code: ____________________ Telephone: ____________________

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 your 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.

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Use separate sheet if necessary

Medications: ______________________________

Allergies: ______________________________

Medical conditions: ______________________________

Recent Injuries: ______________________________

Last Tetanus Shot: ______________________________

Any information not covered above: ______________________________

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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: __________________________