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## PLAYER MEDICAL INFORMATION FORM

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: \_\_\_\_\_