



### 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.

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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: \_\_\_\_\_