PLAYER MEDICAL INFORMATION SHEET

Name:_____09/10 Team_____

Date of Birth: Day:_____ Month:_____ Year:_____ Position_____

Address:_____ City:_____

Province:_____ Postal Code:_____ Telephone#:_____

Medicare #:_____

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

Business Phone #: Mother:_____ Father:_____

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

Name:_____ Telephone:_____

Address:_____

Doctor's Name:_____ Telephone:_____

Dentist's Name:_____ Telephone:_____

Height:_____Weight:_____ Shots:_____

Please circle the appropriate response below pertaining to your child

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	**Yes**	**No**

Please give details below if you answered "Yes" to any of the above questions:

_____

_____

_____

_____

(Extra space on bottom if needed)

Medications Conditions:_____ Medication:_____

Allergies:_____ Last Tetanus Shot:_____

Recent Injuries:_____

Date of last complete physical examination:_____

Any information not covered above:_____

_____

_____

*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 on 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:_____

"SAFETY REQUIRES TEAMWORK

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