

## PLAYER MEDICAL INFORMATION SHEET

Name:						
Date of birth: Day			Month	Year		
Address:						
Postal Code	e:		Telepho	one:		
Provincial F	lealth N	Number:				
Mother's Na	ather's Name:					
Business Te	elephor	ne Numbers	s: Mother	Father's Name:		
Person to c	ontact i	in case of a	ccident or emer	gency, if parents are not available.		
				Telephone:		
				T-lb		
Doctor's Na	ıme:			Telephone:		
Dentist's Na	ame:			Telephone:		
Plea	se circl	e the appro	priate response	below pertaining to you child		
Yes	No	Previous history of concussions				
Yes	No	Fainting 6	episodes during	exercise		
Yes	No	Epileptic				
Yes	No	Wears gla	asses			
Yes	No	Are lense	es shatterproof?			
Yes	No	Wears co	ontact lenses			
Yes	No	Wears de	ental appliance			
Yes	No	Hearing p	problem			
Yes	No	Asthma				
Yes	No	Trouble b	reathing during	exercise		
Yes	No	Heart Co	ndition			
Yes	No	Diabetic				
Yes	No	Has had	an illness lasting	g more than a week in the past year		
Yes	No	Medicatio	on	, ,		
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.
Plea			below if you answered "Yes" to any of the above items.
			Use separate sheet if necessary
Medi	cations	s:	
Aller	gies:		
Medi	cal con	ditions	:
Rece	ent Injui	ries:	
Last	Tetanu	s Shot:	
			ot covered above:
			ete physical examination:
befoi	* Any re partio	/ medic cipatinզ	al condition or injury problem should be checked by your physician g in a hockey program.
can l	change	in the	d that it is my responsibility to keep the team management advised of above information as soon as possible and that in the event no one team management will take my child to hospital/M.D. if deemed
inves			horize the physician and nursing staff to undertake examination ecessary treatment of my child.
as de	l also eemed		rize release of information to appropriate people (coach, physician) sary.
	Date	:	Signature of Parent or Guardian: