**PLAYER MEDICAL INFORMATION SHEET**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # \_\_\_\_\_\_

Date of birth: Day Month Year

Canadian Address:

Postal Code:

Telephone:

Cell Phone:

E Mail ID:

Provincial Health Number: **(Optional)**

Mother’s Name:

Business Telephone Number-Mother Cell:

Father’s Name:

Business Telephone Number-Father Cell:

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

Name: Telephone:

Relationship to player:

Address:

Doctor’s Name:  Telephone:

Dentist’s Name:  Telephone:

Please circle the appropriate response below:

Yes No Previous history of concussions-Number\_\_ Date of last one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 been to a doctor 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history concerns:

Medications:

Allergies:

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 this player to hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of said player.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date:

Signature of Player:

Send to: [Sheldon.adams@sympatico.ca](mailto:Sheldon.adams@sympatico.ca)

CC; [darcyfindlay6@hotmail.com](mailto:darcyfindlay6@hotmail.com)