MEDICAL INFORMATION SHEET

Name: ____________________

Date of birth: Day ________ Month ________ Year ________

Address: ____________________

Postal Code: ____________________

Telephone: (____) ____________ Cell: (____) ____________

Provincial Health Number (optional): ____________________

Parent/Guardian #1: Name ____________________

Business Phone Number:(____) ____________

Parent/Guardian #2: Name ____________________

Business Phone Number:(____) ____________

Alternate emergency contact (if parents are not available)

Name: ____________________

Relationship to Player: ____________________

Telephone: (____) ____________ Cell: (____) ____________

Doctor's Name: ____________________

Telephone: (______) ____________

Dentist's Name: ____________________

Telephone: (______) ____________

Date of last complete physical examination: ____________________

Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes	No	Medication
Yes	No	Allergies
Yes	No	Previous history of concussions
Yes	No	Fainting or seizure during or after physical activity
Yes	No	Near fainting or Brownouts
Yes	No	Seizures and/or epilepsy
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	Palpitations or Racing Heart
Yes	No	Family history of heart disease
Yes	No	Family history of unexpected death during physical activity
Yes	No	Family history of unexplained death of a young person
Yes	No	Diabetes – Type 1____ Type 2______
Yes	No	Wears medical information bracelet/necklace For what purpose? ____________
Yes	No	Health problem that would interfere with participation on a hockey team
Yes	No	Has had an illness that lasted more than a week and required medical attention in the past year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Been admitted to hospital in the last year
Yes	No	Surgery in the last year
Yes	No	Presently injured Injured body part: ____________
Yes	No	Vaccinations up to date Date of last Tetanus Shot: ____________
Yes	No	Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

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Medications: ____________________

Allergies: ____________________

Medical conditions: ____________________

Recent injuries: ____________________

Any information not covered above: ____________________

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I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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 Player: ____________________

Date: ____________ Signature of Parent or Guardian: ____________________

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