MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: (_____) _____ Cell: (___) _____

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

Business Telephone Numbers: Mother _____ Father _____

Alternate emergency contact (if parents are not available)

Name: _____ Telephone: _____

Relationship to player: _____

Address: _____

Doctor's Name: _____ Telephone: (_____) _____

Dentist's Name: _____ Telephone: (_____) _____

Date of last complete physical examination: _____
* Before a player participates in a hockey program, any medical condition or injury problem should be checked by that individual's family physician.

Please circle 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 episodes during exercise
- ☐ 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 Family History of Heart Disease
- ☐ Yes ☐ No Diabetes Type 1 _____ Type 2 _____
- ☐ Yes ☐ No Wears a medical information bracelet or necklace
  For what purpose? _____

☐ Yes ☐ No Has any 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 Has 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

_____

_____

_____

Medications:_____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

I understand that it is my responsibility to keep the team Hockey Trainer 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: _____

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.