Player Medical Information Sheet

Name: _____

Date of Birth: Day_____ Month_____ Year_____

Address:_____

Postal Code:_____ Telephone:_____ Email:_____

Provincial Health Number:_____

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

Business Telephone: Mother:_____ Father:_____

Persons to contact in case of accident or emergency:if parents aren't available

Name:_____ Telephone:_____

Address:_____

Child's Doctor's Name:_____ Telephone:_____

Child's Dentist's Name:_____ Telephone:_____

Please circle the appropriate response below pertaining to your child.

Yes	No	Previous history of concussions?
Yes	No	Fainting episodes during exercise?
Yes	No	Eplileptic?
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	Medications? If any?_____
Yes	No	Allergies? If yes specify:_____