

PLAYER MEDICAL INFORMATION SHEET

Name: _____

Birthdate: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: _____

Alberta Healthcare #: _____

Mothers Name: _____ Fathers Name: _____

Work Phone: _____ Work Phone: _____

Person to Contact in case of accident or emergency, if parents are not available:

Name: _____ Telephone: _____

Address: _____

Doctor's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

Please circle the appropriate response below pertaining to your child:

- | | | | | | |
|-----|----|---|-----|----|---|
| Yes | No | Previous history of concussions | Yes | No | Wears a dental appliance |
| Yes | No | Fainting episodes during exercise | Yes | No | Hearing problem |
| Yes | No | Epileptic | Yes | No | Asthma |
| Yes | No | Wears glasses | Yes | No | Trouble breathing during exercise |
| Yes | No | Are lenses shatterproof? | Yes | No | Heart Condition |
| Yes | No | Wears contact lenses | Yes | No | Diabetic |
| Yes | No | Wears a medic alert bracelet or necklace | Yes | No | Medication |
| Yes | No | Surgery in the last year | Yes | No | Allergies |
| Yes | No | Has been in hospital in the last year | Yes | No | Illness lasting more than a week in the past year |
| Yes | No | Presently injured | Yes | No | Injuries requiring medical attention in the past year |
| Yes | No | Does your child have any health problem that would interfere with participation on a hockey team? | | | |

Please give details below if you answered "Yes" to any of the above:

Medication: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Last Tetanus Shot: _____

Last Complete Physical: _____

Additional information: _____

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/coaches advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management/coaches will take my child to the hospital 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.

Signature of Parent/Guardian: _____

Date: _____