



PARTICIPANT INFO & MEDICAL QUESTIONNAIRE

Name: _____ Date of Birth: _____

Home Phone: _____ Health Number: _____

Mother's Name: _____ Ph. 1: _____ Ph.2: _____

Father's Name: _____ Ph. 1: _____ Ph.2: _____

Address: _____

Email Addresses: _____

Alternate Contact in case of accident or emergency, if parents are can not be reached.

Name: _____ Ph. 1: _____ Ph.2: _____

Doctor's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

NCCP/Hockey Canada Medical Information Questionnaire:

Please circle the appropriate response below.

Previous History of concussions	Yes	No
Fainting episodes during exercise	Yes	No
Epileptic	Yes	No
Wears glasses or lenses	Yes	No
Wears dental appliance	Yes	No
Hearing problem	Yes	No
Trouble breathing during exercise	Yes	No
Asthma	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
Wears a medic alert bracelet or necklace	Yes	No
Surgery in the last year	Yes	No
Has been admitted to hospital in the last year	Yes	No
Has had injuries requiring medical attention in the past year	Yes	No
Presently injured	Yes	No

Please give details on reverse if you answered "yes" to any of the above items, and include date of most recent incident and area of the body for injuries.

