PLAYER MEDICAL INFORMATION SHEET

Name:_____ D.O.B. Day_____ Month _____ Year _____

Address:_____Town:_____
Postal Code:_____ Telephone: _____ A.H.C.#: (Optional) _____

Mothers Name: _____Fathers Name: _____

Home Telephone: _____Home Telephone: _____

Business Telephone: _____Business Telephone: _____

Cellular Phone: _____Cellular Phone: _____

Person to contact in case of accident or emergency, if parents are not available:
Name: _____ Telephone: _____

Doctor's Name: _____Telephone:_____

Dentist's Name: _____Telephone:_____

Please circle the appropriate response pertaining to your child:

Yes	No	Previous history of concussions
Yes	No	Fainting episodes during exercise
Yes	No	Epileptic
Yes	No	Wears glasses If **Yes**, Are lenses shatterproof? Yes No
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	Medication
Yes	No	Allergies
Yes	No	Wears a medic alert bracelet or necklace
Yes	No	Does your child have any health problems that would interfere with participation on a baseball team?
Yes	No	Has had surgery in the last year
Yes	No	Has been in the hospital for the last year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	presently injured

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If you answered "Yes" to any of the above items, please provide details below:

_____

_____

Medications:_____

Allergies:_____

Medical Conditions:_____

Recent Injuries:_____

Last Tetanus Shot:_____

Any information not covered_____

Date of last physical exam: _____

_____

***Any medical condition or injury problem should be checked by your physician before participating in any baseball program.**

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take my child to the hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.

I authorize release of information to appropriate people (coach, physician) as deemed necessary.

Signature of Parent/Guardian: _____Date: _____

Website and Media Release Form

I hereby consent to and authorize the use and reproduction by Innisfail Minor Ball of any and all photographs, video recording or audio recordings taken of

_____

(Name of Participant)

For use on Innisfail Minor Ball website in print and other media for the purpose of promotion, illustration, advertising, or publication, without compensation. All recorded media, prints and created media from the content shall constitute the property of Innisfail Minor Ball Association.

_____ _____

Participant Signature Date

_____

Mailing Address City

_____

Province Postal Code Phone Number

I hereby certify that I am the Parent or Legal Guardian of

_____

And I do give my consent on his/her behalf.

_____ _____

Signature of Parent or Guardian Date