Okotoks Minor Hockey Association

"Practice and play like a champion today!"

Box 1152 Okotoks, Alberta T1S 1B2
403.710-2213 operations@okotokshockey.com
www.okotokshockey.com

PLAYERS MEDICAL INFORMATION FORM

Name _____
Date of Birth: Day _____Month _____ Year_____
Address:

_____
Postal Code: _____
Telephone:_____
Provincial Health Care Number: _____
Mother's Name: _____
Father's Name: _____
Business Telephone Numbers: Mother: _____
Father: _____
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 Fainting episodes during exercise
Yes No Epileptic
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

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Yes No Has had an illness lasting more than a week in the past year
Yes No Medication
Yes No Allergies
Yes No Does your child have any health problem that would interfere with participation on a hockey team
Yes No Surgery in the last year
Yes No Has been in hospital in the last year
Yes No Has had injuries requiring medical attention in the past year
Yes No Presently injured
Yes No Heart Condition
Yes No Diabetic

Please give details below if you answered "Yes" to any of the above items.
Use separate sheet if necessary
Medications:

_____

Allergies:

_____

Medical Conditions:

_____

Recent Injuries:

_____

Last Tetanus Shot:

_____

Any information not covered above:

_____

Date of last complete physical examination:

_____

Any medical condition or injury problem should be checked by your physician before participating in a hockey program.

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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 hospital/M.D. if deemed necessary. I herby authorize the physician and nursing staff to undertake an examination investigation and necessary treatment of my child.

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

Date: _____

Signature of Parent or Guardian: _____