

MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number (optional): _____

Parent/Guardian #1: Name _____

Business Phone Number: (____) _____

Parent/Guardian #2: Name _____

Business Phone Number: (____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Telephone: (____) _____

Dentist's Name: _____

Telephone: (____) _____

Date of last complete physical examination: _____

Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.Yes ☐ No ☐ MedicationYes ☐ No ☐ AllergiesYes ☐ No ☐ Previous history of concussionsYes ☐ No ☐ Fainting or seizure during or after physical activityYes ☐ No ☐ Near fainting or BrownoutsYes ☐ No ☐ Seizures and/or epilepsyYes ☐ No ☐ Wears glassesYes ☐ No ☐ Are lenses shatterproofYes ☐ No ☐ Wears contact lensesYes ☐ No ☐ Wears dental applianceYes ☐ No ☐ Hearing problemYes ☐ No ☐ AsthmaYes ☐ No ☐ Trouble breathing during exerciseYes ☐ No ☐ Heart ConditionYes ☐ No ☐ Palpitations or Racing HeartYes ☐ No ☐ Family history of heart diseaseYes ☐ No ☐ Family history of unexpected death during physical activityYes ☐ No ☐ Family history of unexplained death of a young personYes ☐ No ☐ Diabetes – Type 1 _____ Type 2 _____Yes ☐ No ☐ Wears medical information bracelet/necklace For what purpose? _____Yes ☐ No ☐ Health problem that would interfere with participation on a hockey teamYes ☐ No ☐ Has had an illness that lasted more than a week and required medical attention in the past yearYes ☐ No ☐ Has had injuries requiring medical attention in the past yearYes ☐ No ☐ Been admitted to hospital in the last yearYes ☐ No ☐ Surgery in the last yearYes ☐ No ☐ Presently injured Injured body part: _____Yes ☐ No ☐ Vaccinations up to date Date of last Tetanus Shot: _____Yes ☐ No ☐ Hepatitis B vaccination**Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)**

Medications: _____

Recent injuries: _____

Allergies: _____

Any information not covered above: _____

Medical conditions: _____

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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.

Date: _____

Signature of Player: _____

Date: _____

Signature of Parent or Guardian: _____

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