MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: (____) _____

Provincial Health Number (optional): _____

Mother's Name: _____ Father's Name: _____

Business Telephone Numbers: Mother _____ Father _____

Alternate emergency contact (if parents are not available)

Name: _____ Telephone: _____

Address: _____

Doctor's Name: _____ Telephone: (____) _____

Dentist's Name: _____ Telephone: (____) _____

Date of last complete physical examination: _____

* Before a player participates in a hockey program, any medical condition or injury problem should be checked by that individual's family physician.

Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

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
Yes	No	Heart Condition
Yes	No	Diabetic – Type 1_____ Type 2_____
Yes	No	Medication
Yes	No	Allergies

Yes	No	Wears a medical information bracelet or necklace For what purpose? _____
Yes	No	Has any health problem that would interfere with participation on a hockey team
Yes	No	Has had an illness that lasted more than a week and required medical attention in the past year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Has been admitted to hospital in the last year
Yes	No	Surgery in the last year
Yes	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: _____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

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 Parent or Guardian: _____

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