Millet Minor Hockey Association
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Email: mmha@milletminorhockey.com Website: www.milletminorhockey.com

Medical Form

Season: ________________

Last Name ____ First Name ________________________________Middle Initial _______

Address ____ City____________________ Province_________ Postal Code___________

Date of Birth _____/_____/_____ (Month/Day/Year) Alberta Health Care Number: ________________________ Home Number: ________________________

FOR EMERGENCY CONTACT: Name ____Relationship:__________________________

Address _____________________________________ Home #:_________________________Cell #:___________________________

Family Doctor: ____ Phone Number: ___________________________________

Date of Last Physical: _______________________ (Month / Year)

Family Dentist: ____ Phone Number: ___________________________________

Year(s) of Participation in Hockey (circle): 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th

What position will you want to play this year? ________________________

Explain "Yes" answers below:

	YES	NO
1. Have you ever been hospitalized?	o	o
Have you ever had surgery?	o	o
2. Are you presently taking any medications or pills?	o	o
Are you presently taking any vitamins or supplements?	o	o
3. Do you have any allergies (medicine, bees or other stinging insects)?	o	o
4. Have you ever passed out during or after exercise?	o	o
Have you ever been dizzy during or after exercise?	o	o
Have you ever had chest pain during or after exercise?	o	o
Do you tire more quickly than your friends during exercise?	o	o
Have you ever had high blood pressure?	o	o
Have you ever been told that you have a heart murmer?	o	o
Have you ever had racing of your heart or skipped heartbeats?	o	o
Has anyone in your family died of heart problems or a sudden death before age 50?	o	o
5. Do you have any skin problems (itching, rashes, acne)?	o	o
6. Have you ever had heat or muscle cramps?	o	o
Have you ever been dizzy or passed out in the heat?	o	o
7. Do you have trouble breathing or do you cough during or after activity?	o	o
8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	o	o
Do you use any dental appliances?	o	o
9.Have you had any problems with your eyes or vision?	o	o
Do you wear glasses or contacts or protective eye wear?	o	o
10. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	o	o
11. Have you had a medical problem or injury since your last evaluation?	o	o
12. Have you had any unexplained weight change?	o	o

13. When was your last tetanus shot? ________________________

When was your last measles immunization? ____________________

	YES	NO
14. Female Athletes: Over the past year, did your periods occur about once a month?	o	o

Explain "Yes" answers

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Continued ……

HEAD INJURIES / CONCUSSIONS:

	YES	NO
15. Have you ever had a seizure?	o	o
16. Have you ever had a head injury?	o	o
Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"?	o	o

If YES, please list: Number: ______

Date(s)	Activity at the time	Length of unconsciousness (minutes)	Length of time before full return to activity

Did you have any persistent problems with:

Memory: YES / NO Dizziness: YES / NO Headaches: YES / NO

NECK INJURIES / BURNERS / STINGERS:

	YES	NO
17. Have you ever had a neck injury (i.e, strain, sprain, fracture, etc.)	o	o
18. Have you ever had a stinger, burner or pinched nerve?	o	o

(a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - aka. "brachial plexus stretch injury")

If YES, please list: Number: ______

Date(s)	Activity at the time	Length of time sensation/strength changes persisted?

19. Check any of the areas that you have INJURED IN THE PAST and explain the injury below:

Hand ___	Elbow ___	Neck ___	Hip ___	Shin/Calf ___
Wrist ___	Arm ___	Chest ___	Thigh ___	Ankle ___
Forearm ___	Shoulder ___	Back ___	Knee ___	Foot ___

Year of Injury	Type of Injury	Side (right, left, both)	Is it still a problem? (Yes / No)

	YES	NO
20. Do you have any incompletely healed injury?	o	o

If yes, which injury? ______________________________

I hereby certify the above information to be correct & in the event of a medical emergency consent to release the information provided on this form to an authorized professional, so that he/she may start an examination on the person above in my absense.

______________________________ ______________________

Players' Signature **Date**

______________________________ ______________________

Parent / Guardian Signature **Date**

The information given on this medical form will be held in confidence and placed into a sealed envelope along with all medical forms of the player's for this hockey season. The coach of the player's will be held responsible for keeping the sealed envelope in his/her possession while involved with MMHA for that season. The coach will only open the sealed envelope if he/she deems it necessary in the case of an emergency.

It is always important to discuss any medical problems with the coach.