SCMHA Player Emergency Information Sheet

Players Name: _____ Date of Birth: _____
Address: _____ Postal Code: _____
Tel: Home: _____ Work: _____
Health Insurance #_____
Mothers Name: _____Father's Name: _____
Phone Numbers to contact: Mother work: _____home: _____
Father work: _____home_____

Person to contact in case of emergency, if parents is not available.
Name: _____
Tel: Home: _____ Work: _____
Relationship to Player: _____

Family Doctor: _____ Tel: _____
Dentist's Name: _____Tel: _____

Important *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
Yes	No	Heart Condition
Yes	No	Diabetic
Yes	No	has had an illness lasting more than a week in the past year
Yes	No	Wears a medic alert bracelet or necklace
Yes	No	Any health problems that would interfere with playing hockey?
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.

Please give detail below if you answered "Yes" to any of the above items.

Allergies to medications? _____

Any other allergies? (I.e. food allergies, tape latex, etc.)
_____

On any regular medication, is so what? _____

Last Tetanus Shot: _____

Any other pertinent information not covered:

*Your physician prior to participating in a hockey program should check any medical condition or injury.

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 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 peoples (coach, physician) as deemed necessary.

Parents/Guardians Signature: _____Date: _____