AMRA Player Medical Form

www.arnpriorringette.ca

Player Information

Last Name:	First Name:
Gender: ☐ Male ☐ Female	OHIP Number: *(Optional)*
Age: (As of December 31 of this year)	Birth Date: (yyyy/mmm/dd) ____/____/____

Family Information

Mother:	Father:
Address:	Address:
City:	City:
Phone: (H) (W) (C)	Phone: (H) (W) (C)

Medical Condition

Alergies (please list all):

Medications:

Other Relevant Medical Conditions:

Emergency Contact Information:

Name:	Relationship:	Phone: (H) (W) (C)

Player General Health

Please respond yes or no to the following questions:

- ☐ Yes ☐ No Previous history of concussion?
- ☐ Yes ☐ No Fainting episodes during exercise?
- ☐ Yes ☐ No Epileptic?
- ☐ Yes ☐ No Wears glasses?
- ☐ Yes ☐ No If player wears glasses, are glasses shatter proof?
- ☐ Yes ☐ No Wears contact lenses?
- ☐ Yes ☐ No Wears dental appliance?
- ☐ Yes ☐ No Has problems hearing?
- ☐ Yes ☐ No Asthma or other chronic breathing problem?
- ☐ Yes ☐ No Has trouble breathing during exercise?
- ☐ Yes ☐ No Heart condition?
- ☐ Yes ☐ No Diabetic? If so, Type 1 or Type 2
- ☐ Yes ☐ No Takes medication? (must be listed above).
- ☐ Yes ☐ No Allergies? (must be listed above).
- ☐ Yes ☐ No Requires Epi-pen?
- ☐ Yes ☐ No Wears a medical information bracelet or necklace? If so, for what purpose?
- ☐ Yes ☐ No Any other medical condition not listed which would prevent participation on a ringette team? If so, list:

I understand that it is my responsibility to keep the teams Coach and Trainer 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, bench staff 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.

Parent or Guardian Signature:	Print Name:	Date: