HALIFAX HURRICANES RINGETTE ASSOCIATION

2.3.1 – Emergency Medical Information Form

Name: ____

Last First Middle

Address: ____

Postal Code: ______________________________ **Phone Number:** _________________________________

Date of Birth: Month______ Day______ Year______ **NSHC#:** _______________________________________

Next of Kin: _______________________________ **Relationship:** ____________________________________

Address, same as above or: ____

Phone Number, same as above or: ____

Family Doctor: _____________________________ **Phone Number:** _________________________________

RELEVANT MEDICAL HISTORY:

Medications: ____

Allergies (medications, antibiotics): ____

Allergies (food, beverages): ____

Date of last Tetanus Shot: ____

Previous Injuries: ____

Major Operations: ____

Contact Lenses: Yes No **Type:** ____

Describe any medical problems that the coaching staff of this team should be aware of (e.g. epilepsy, diabetes, etc.)

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I, THE UNDERSIGNED PARENT/GUARDIAN HEREBY GIVE MY PERMISSION FOR THE COACH, ASSISTANT COACH, MANAGER OR TRAINER TO AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS MAY BE REQUIRED.

Signed: ____

Date: ____