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.)

_____

_____

_____

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: _____