NCRA Player Medical Information

Player Information

			Team			
Name			Date of Birth	Y	M	D
Address			MSI#			
City		Postal		Prov.		
Phone		Email				
Parent/Guardian		Parent Guardian				
Phone		Phone				
Cell		Cell				
Work		Work				

Emergency Contact(s) if parent/guardian unavailable:

Name		Name	
Phone		Phone	
Address		Address	

Medical Information:

Doctor's Name		Phone	
Dentist's Name		Phone	

 Allergies (medication, foods, etc.)

_____

Medical conditions (Asthma, Diabetes, Epilepsy, etc):

_____

_____

Medications (name and dosage):

_____

_____

Previous Injuries and Dates (concussions, neck injuries, sprains, etc.):

_____

Last Tetanus Shot Date:		Last complete physical examination	

Please circle the appropriate response below pertaining to your child:

Previous history of concussions?	Yes	No	Heart Condition?	Yes	No
Fainting episodes during exercise?	Yes	No	Had an illness lasting more than one week in the past year?	Yes	No
Wears glasses?	Yes	No	Wears a medic alert bracelet or necklace?	Yes	No
Glass lenes shatterproof?	Yes	No	Surgery in the last year?	Yes	No
Contact lenes?	Yes	No	Has been in the hospital in the last year?	Yes	No
Dental appliance, braces or retainer?	Yes	No	Has had injuries requiring medical attention in the past year?	Yes	No
Hearing problems?	Yes	No	Presently injured?	Yes	No
Trouble breathing during exercise?	Yes	No	Any health problem that would interfere with participation on a ringette team?	Yes	No

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

_____

_____

Other medical conditions we should be aware of:

_____

_____

Any medical condition or injury should be checked by your physician before participating in a Ringette Program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible

Medical Waiver

I certify all information above to be complete and correct. Nova Central Ringette Association and/or Ringette Nova Scotia is not responsible for any injuries sustained by my child during the program.

I hereby authorize the team staff or program volunteers to seek medical assistance when required for my child and for medical care to be administered.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

_____
Parent or Guardian Print Name

_____   _____
Signature of Parent or Guardian   Date: