



Axemen Lacrosse Association

MEDICAL FORM

(Please Print)

Season Year:						
PLAYER INFORMATION						
Last Name:		First:		Middle:		
Birth date: (mm/dd/yyyy) / /		Age:		Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
Home Address:				Primary #: ()		
City:			Prov:		Postal Code:	
Health Card Number:						
Date of Last Physical Examination: <i>Before a player participates in a lacrosse program, any medical condition or injury should be checked by that individual's family doctor.</i>						
Doctor's Name:			Telephone #:			
Dentist's Name:			Telephone #:			
PLAYER MEDICAL INFORMATION						
<i>Please circle the appropriate response and provide details below if you answer 'YES' to any of the questions:</i>						
YES	NO	CONDITION		YES	NO	CONDITION
		Previous history of concussions				Medication
		Fainting episodes during exercise				Allergies
		Epileptic				Wears a medical information bracelet or necklace
		Wears glasses				Has any health problem that would interfere with participation on a lacrosse team
		Wears contact lenses				Has had an illness that lasted more than a week and required medical attention in the past year
		Hearing difficulties				Had had injuries requiring medical attention in the past year
		Asthma				Has been admitted to hospital in the last year
		Trouble breathing during exercise				Surgery in the last year
		Heart conditions				Presently Injured - BodyPart: _____
		Vaccinations are up to date Date of last tetanus: _____				Hepatitis B vaccination
		Diabetic	Type 1:	Type 2:		
Please give details if you answered 'yes' to any of the above. Include any information not covered above. Use a separate sheet if necessary.						

PARENT (S) INFORMATION

Parent/Guardian 1:		First:	
Primary Phone #: ()		Cell Phone #: ()	
Parent/Guardian 2:		First:	
Primary Phone #: ()		Cell Phone #: ()	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to player:	Primary Phone #: ()	Cell phone #: ()
<p>I understand that it is my responsibility to keep the team Coach and Trainer advised of any change in the above information as soon as possible. In the event of a medical emergency and no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary.</p> <p>I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.</p> <p>I also authorize the release of information to appropriate people i.e. coach, trainer, physician as deemed necessary.</p>			
<i>Parent/Guardian signature:</i>		<i>Date:</i>	

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