

AYR ROCKETS MEDICAL FORM

MEDICAL INFORMATION SHEET

Date of birth: Day Month Year Name: Address: Relationship to Player: Coll: (Name:					Alternate emergency contac	ct (if pa	rents ar	re not available)	
Address: Relationship to Player:	Date of birth: Dav Month Year					Name:	Name:			
Postal Code:	·						- Relationship to Player:			
Telephone:						Telephone: ()	Telephone: () Cell: ()			
Previncial Health Number (optional):	Postal	Code: _				Doctor's Name:				
Parent/Guardia #2: Name	Teleph	one: ()Cell: ()		Telephone: ()_			
Business Phone Number:	Previn	ial Heal	th Number (optional):			De ntist 's Name:	De ntist's Name:			
Business Phone Number:	Parent	/Guardi	an #1: Name			Telephone: (>_			
Parent/Guardian #2: Name Before a player participates in a hockey program it is recommended that they have a medical and that they have a medical and that they have a medical and that they have a medical condition or injury problem decked by their participation Parent/Guardian #2: Name		,								
Business Phone Number:	Davaat	Current				Before a player participates in				
Yes: No Medication Yes: No Asthma Yes: No Health problem that would interfere with participation on a hocky team Yes: No Altergies Yes: No Touble breathing during exercise Yes: No Hashad an liness that lated more than a week and required medical attention in the past year Yes: No Fainting or seizure during or after Yes: No Fainting or Brownouts Yes: No Fainting or Brownouts Yes: No Fainting or Brownouts Yes: No Been admitted to hospital in the last year Yes: No Fainting brownout Yes: No Fainting brownout Yes: No Paesen admitted to hospi	Parent	Guardi								
Yes: No Medication Yes: No Asthma Yes: No Health problem that would interfere with participation on a hocky team Yes: No Altergies Yes: No Touble breathing during exercise Yes: No Hashad an liness that lated more than a week and required medical attention in the past year Yes: No Fainting or seizure during or after Yes: No Fainting or Brownouts Yes: No Fainting or Brownouts Yes: No Fainting or Brownouts Yes: No Been admitted to hospital in the last year Yes: No Fainting brownout Yes: No Fainting brownout Yes: No Paesen admitted to hospi	Dianco	chock t	he contractions and prov	rido dotaile bol	ou if yo	u answer "Vec" to any of the questions				
Yes: No Allergies Yes: No Touble breathing during exercise Yes: No Heart Condition Yes: No Has had an illness that lasted more than a week and required medical attention in the past year Yes: No Fainting or seizure during or after Yes: No Palpitations or Racing Heart Yes: No Near fainting or seizure during or after Yes: No Palpitations or Racing Heart Yes: No Near fainting or Brownouts Yes: No Family history of unexplected death during physical activity Yes: No Been admitted to hospital in the last year Yes: No Seizures and/or epilepsy Yes: No Diabetes - Type 1 Yes: No Been admitted to hospital in the last year Yes: No Wears glasses Yes: No Diabetes - Type 1 Type 2 Yes: No Presently injured Yes: No Wears dental appliance Yes: No Diabetes - Type 1 Type 2 Yes: No Palpitations brocket/recklace Yes: No Wears dental appliance Yes: No </th <th></th> <th></th> <th></th> <th></th> <th>-</th> <th></th> <th>Yes 🗆</th> <th>No口</th> <th>Health problem that would interfere with</th>					-		Yes 🗆	No口	Health problem that would interfere with	
Yes No Previous history of concussions Yes No Heart Condition than a week and required medical attention in the past year Yes No Fainting or seizure during or after yes No Palpitations or Racing Heart Yes No Heart Acting yes Yes No No Rearity history of mechanismic or seizures and yor epilepsy Yes No Family history of mechanismic or seizures and/or epilepsy Yes No Bean Admitted to hospital in the last year Yes No Seizures and/or epilepsy Yes No Family history of unexplained death of a young person Yes No Been admitted to hospital in the last year Yes No Are lenses shatterproof Yes No Bamily history of unexplained death of a young person Yes No Pareity history of week yeek death Yes No Are lenses shatterproof Yes No Baetes - Fipe 1 Yes No Previous history of week yeek and appliance Yes No Wears medical information braceley hecklace for what purpose? Yes No Heart Sent history of week yeek and appliance Yes No Hearing problem Yes <td< td=""><td>Yes□</td><td>Noロ</td><td>Allergies</td><td>Yes 🗆</td><td>No 🗆</td><td>Trouble breathing during exercise</td><td></td><td></td><td>participation on a hockey team</td></td<>	Yes□	Noロ	Allergies	Yes 🗆	No 🗆	Trouble breathing during exercise			participation on a hockey team	
Yes No Fainting or seizure during or after physical activity Yes No Palpitations or Racing Heart attention in the pastylear Yes No Near fainting or Brownouts Yes No Faintly history of unexpected death during physical activity Yes No Been admitted to looptal in the lastylear Yes No Kears glasses Yes No Faintly history of unexpected death during physical activity Yes No Been admitted to looptal in the lastylear Yes No Are lenses shatterproof Yes No Babets - Type 1 Type 2 No Presently injured injured injured boly part: Yes No Wears deatal appliance Yes No Babets - Type 1 Type 2 No Presently injured injured injured injured injured injured boly part: Yes No Wears deatal appliance Yes No Babets - Type 1 Yes No Presently injured injured injured injured injured injured injured injured injured injures: Yes No Hearing problem Yes No Hearing problem Yes No Heapititis B vaccination Medications:	Yes 🗆	Noロ	Previous history of concussions	Yes 🗆	No 🗆	Heart Condition	Yes 🗆	Noロ		
Yes No Family firstory of heard disease attention in the pastyear Yes No Family history of unexpected death during physical attrivity Yes No Been admitted to hospital in the lastyear Yes No Seizures and/or epilepsy Yes No Family history of unexplained death of a young person Yes No Been admitted to hospital in the lastyear Yes No Are lenses shatterproof Yes No Family history of unexplained death of a young person Yes No Surgery in the last year Yes No Are lenses shatterproof Yes No Biabetes - Type 1 Type 2 Injured body part: Yes No Wears contact lenses Yes No Wear medical information bracelet/neckace For what purpose? Yes No Yes No Hearing problem Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)	Yes□	Noロ		r Yes 🗆	Noロ	Palpitations or Racing Heart				
res No No Family history of unexpected death during physical activity Yes No Been admitted to hospital in the last year Yes No Wears glasses Yes No Family history of unexplained death of a young person Yes No Breen admitted to hospital in the last year Yes No Are lenses shatterproof Yes No Diabetes - Type 1 Type 2 Yes No Presently injured Injured body part: Yes No Wears contact lenses Yes No Diabetes - Type 1 Type 2 Yes No Vacinations up to date Date of last Tetanus Shot: Yes No Wears medical information bracelet/necklace Yes No Hepatitis B vaccination Ves No Hearing problem Yes No Hepatitis B vaccination Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)				Yes 🗆	Noロ	Family history of heart disease	Yes 🗆	Noロ		
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Ites No Wears gasses Feed No Presently injured and a young person				V~ □		51 5	Yes 🗆	Noロ	, ,	
Yes No Wears contact lenses Yes No Diabetes - Type 1 Type 2 Injusted body parts Yes No Wears dental appliance Yes No Yes No Vaccinations up to date Date of last letanus Shot: Yes No Hearing problem Yes No Hepatitis B vaccination Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)			3	res 🗆	NOL		Yes 🗆	Noロ		
Yes No Wears medical information bracelet/necklace Heat of last Tetanus Shot: Yes No Hearing problem Yes No Hearing problem Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)				Yes 🗆	Noロ	Diabetes – Type 1 Type 2		Injured	body part:	
Yes No Hearing problem Yes No Hepatitis B vaccination Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)				Yes 🗆	No 🗆		Yes 🗆			
Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary) Medications:						For what purpose:	Yes 🗆	No	Henatitis R vaccination	
Medications:	les		nearing problem						reputers b facemation	
Allergies: Any information not covered above: Medical conditions:	Plea	ise give	details if you answered "Yes" to a	any of the abov	ve. (Use	separate sheet if necessary)				
Allergies: Any information not covered above: Medical conditions:										
Allergies: Any information not covered above: Medical conditions:										
Allergies: Any information not covered above: Medical conditions:	Mod	ications				Recent injuries.				
Medical conditions:						-				
I understand that it is my responsibility to keep the team Safety Person 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, team management 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. Date: Signature of Player: Date: Signature of Parent or Guardian:	Alle	rgies:				Any information not cover	Any information not covered above:			
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Date: Signature of Parent or Guardian:	D.4.									
•	Date Signature of Player:							_		
· ·	Date: _		Siqi	ature of Paren ⁴	t or Gua	rdian:				
National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as Hockey Canada's own Privacy Policy.	Disclai	mer: Pers	sonal information used, disclosed, s	ecured or retain	ed by Ho	ockey Canada will be held solely for the purpo	oses for v	which we	collected it and in accordance with the	