



BARRIE AND DISTRICT RINGETTE ASSOCIATION

Medical Information Form

Child and Parent Information

_____	_____	M	F
Child's Name	Date of Birth	Sex	
_____	_____		
Parent's/Guardians Name	Parent's/Guardians Name		
_____	_____		
Home Phone	Work Phone	Home Phone	Work Phone
_____	_____		
Address	Address		
_____	_____		
City, Province, Postal Code	City, Province, Postal Code		

Alternate Emergency Contacts (If parents are not available)

_____	_____		
Primary Emergency Contact	Secondary Emergency Contact		
_____	_____		
Parent's/Guardians Name	Parent's/Guardians Name		
_____	_____		
Home Phone	Work Phone	Home Phone	Work Phone
_____	_____		
Address	Address		
_____	_____		
City, Province, Postal Code	City, Province, Postal Code		

Medical Information

_____	_____
Physicians Name	Phone Number
_____	_____
Dentist's Name	Phone Number

Date of last complete physical Examination

**Before a player participates in a ringette program, any medical condition or injury problem should be checked by that individual's family physician.



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Please check the appropriate response and provide details if you answer "Yes" to any of the questions:

- Yes No Previous history of concussion.
- Yes No Fainting episodes during exercise.
- Yes No Epileptic.
- Yes No Wear glasses-if yes, are lens shatter proof:
- Yes No Wear contact lenses.
- Yes No Wear dental appliance.
- Yes No Hearing problem.
- Yes No Asthma.
- Yes No Trouble breathing during exercise.
- Yes No Heart problem.
- Yes No Diabetic- if yes circle the applicable: Type 1 Type 2
- Yes No Medications. If yes, please list: _____
- Yes No Wears a medical information bracelet or necklace.
If yes, for what purpose? _____
- Yes No Allergies. If yes, please list: _____
- Yes No Has any health problem that would interfere with participation on a ringette team.
- Yes No Has had an illness that lasted more than a week & required medical attention in the past year.
- Yes No Has had injuries requiring medical attention in the past year.
- Yes No Surgery in the past year.
- Yes No Presently injured. Injured body part if yes, what is the injury _____
- Yes No GIRLS ONLY: Has your daughter started her menstrual cycle?
If not is she informed. Yes No
- Yes No Vaccinations up to date. Date of last tetanus shot: _____



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Health Card Number: _____

Any information or medical conditions not covered above:

I understand that it is my responsibility to keep the team Trainer/Manager 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 Parent/Guardian: _____

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.