



PLAYER MEDICAL INFORMATION SHEET

Player Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number: _____

Parent/Guardian #1: Name _____

Cell Phone Number: (____) _____

Parent/Guardian #2: Name _____

Cell Phone Number: (____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Clinic Name: _____

Telephone: (____) _____

Dentist's Name: _____

Telephone: (____) _____

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.Yes ☐ No ☐ MedicationYes ☐ No ☐ AllergiesYes ☐ No ☐ Previous history of concussionsYes ☐ No ☐ Fainting or dizziness during or after physical activityYes ☐ No ☐ Seizures and/or epilepsyYes ☐ No ☐ Wears glassesYes ☐ No ☐ Are lenses shatterproofYes ☐ No ☐ Wears contact lensesYes ☐ No ☐ Wears dental applianceYes ☐ No ☐ Hearing problemYes ☐ No ☐ AsthmaYes ☐ No ☐ Trouble breathing during exerciseYes ☐ No ☐ Heart ConditionYes ☐ No ☐ Palpitations or Racing HeartYes ☐ No ☐ Family history of heart diseaseYes ☐ No ☐ Family history of unexpected death during physical activityYes ☐ No ☐ Family history of unexplained death of a young personYes ☐ No ☐ Diabetes – Type 1 _____ Type 2 _____Yes ☐ No ☐ Wears medical information bracelet/necklace
For what purpose? _____Yes ☐ No ☐ Health problem that would interfere with participation on a hockey teamYes ☐ No ☐ Has had an illness that lasted more than a week and required medical attention in the past yearYes ☐ No ☐ Has had injuries requiring medical attention in the past yearYes ☐ No ☐ Been admitted to hospital in the last yearYes ☐ No ☐ Surgery in the last yearYes ☐ No ☐ Presently injured

Injured body part: _____

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

Medications: _____

Recent injuries: _____

Allergies: _____

Any information not covered above: _____

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 Parent or Guardian: _____

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