ATHLETE MEDICAL INFORMATION

Athlete Name _____
Date of birth: Day _____ Month _____ Year _____
Address:_____ Postal Code: _____
Provincial Health Number (optional) _____

Parent/Guardian #1_____
Contact number(s) _____
Parent/Guardian #2 _____
Contact number(s) _____
Alternate emergency contact (if parents are not available)
Name: _____ Relationship to Player: _____
Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____ Telephone: (____)_____
Dentist's Name: _____ Telephone: (____)_____
Date of last complete physical examination: _____

* Before a player participates in a lacrosse program, any medical condition or injury problem should be checked by that individual's family physician. Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes / No Medications Yes / No Allergies
Yes / No Previous history of concussions
Yes / No Fainting episodes during exercise
Yes / No Seizures and/or epilepsy
Yes / No Wears glasses Yes / No Are lenses shatterproof Yes / No Wears contact lenses
Yes / No Wears dental appliance Yes / No Hearing impairments
Yes / No Asthma Yes / No Trouble breathing during exercise
Yes / No Heart Condition Yes / No Family history of heart disease
Yes / No Diabetes – Type 1_____ Type 2_____
Yes / No Wears a medical information bracelet or necklace For what purpose?_____
Yes / No Has any health problem that would interfere with participation on a lacrosse team?
Yes / No In this past year, has the athlete had an illness that lasted more than a week and required medical attention?
Yes / No Has had injuries requiring medical attention in the past year?
Yes / No Has been admitted to hospital in the last year?
Yes / No Has had surgery in the last year
Yes / No Presently injured. Injured body part (s)_____
Yes / No Vaccinations up to date. If not please indicate those missing
_____

Medications:_____
_____
Allergies:
_____
_____

Recent injuries details / dates / medical attention received or currently receiving:
_____
_____
_____
_____
_____
_____

Please give details if you answered “Yes” to any of the above and have not already provided details, please expand. Use separate sheet if necessary.
_____
_____
_____
_____
_____
_____

I understand that it is my responsibility to keep the Team coaches / managers / trainers 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.

Signature of Player: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____