Brooks Lacrosse Association

Player Medical Information Sheet

Player's Name: ______________________________DOB: Day_____ Month_____ Year______

Address: ____

Primary Phone: __________________

Alberta Heath Care: __________-___________

Mother's Name: ______________________ Phone #: ______________________________

Father's Name: ______________________ Phone #: ______________________________

Person or Person's to contact in case of accident or emergency, if parents are not available:

Name: __________________________________ Phone # _______________________________

Name: __________________________________ Phone # _______________________________

Doctor's Name: _________________________ Phone # _______________________________

Dentist's Name: _________________________ Phone # _______________________________

Please answer the following questions:

	Yes	No
Previous history of concussions	☐	☐
Fainting episodes during exercise	☐	☐
Epileptic	☐	☐
Wears glasses	☐	☐
Are the lenses shatterproof	☐	☐
Wears contact lenses	☐	☐
Wears dental appliance	☐	☐
Hearing problem	☐	☐
Asthma	☐	☐
Trouble breathing during hard running	☐	☐

Brooks Lacrosse Association

Heart condition	☐	☐
Diabetic	☐	☐
Questions cont.	**Yes**	**No**
Allergies	☐	☐
Has had an illness lasting more than a week or has been hospitalized in the past year	☐	☐
Surgery in the past year	☐	☐
Has had injuries requiring medical attention in the past year	☐	☐
Presently injured	☐	☐

Please give details below if you answered "yes" to any above items:

____
____
____
____

Use back of form if necessary

Medications:

____

Last Tetanus shot: ______________________ **Last Physical:** ____________________________

Any information not covered:____
____
____
____

Any medical condition or injury problem should be checked by your physician before participating in a lacrosse program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible

In the event no one can be contacted, team management will take my child the hospital /M.D 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 the appropriate people (coach, physician) as deemed necessary

Brooks Lacrosse Association

Date: __________ Signature of Parent or Guardian: ________________________________