



PARTICIPANT INFORMATION FORM

Players Name: _____ Birth Date: _____

Home Address: _____ Phone Number: _____

Email: _____

PERSONS TO BE CONTACTED IN CASE OF AN EMERGENCY:

Mother: _____

Phone Nos: Day: _____ Evenings: _____ Cell: _____

Father: _____

Phone Nos: Day: _____ Evenings: _____ Cell: _____

Alternative Contact: _____

Phone Nos: Day: _____ Evenings: _____ Cell: _____

Family Doctor & Phone #: _____

Alberta Health Number: _____

RELEVANT MEDICAL HISTORY

Medications: _____ Can they administer own medications _____

Allergies: _____

Previous Injuries: _____

Has Participant ever had a concussion: Yes ___ or No ___

If so how many and Date of Last Concussion: _____

Other Conditions: _____

Parents Signature _____

Date: _____