Camrose Minor Baseball Association
Box 1033
Camrose AB. T4V-4E7
www.camroseball.com

Player Safety/Medical Information

Player's Name: _____ **Players Date of Birth:** _____

Parent's Name(s): _____

Address: _____

Home Phone: _____ **Cell#1:** _____ **Cell#2:** _____

Emergency Contact Name & Phone Number: _____

Doctor's Name and Phone Number: _____

Alberta Health Care#: _____

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

Yes ❑ No ❑ Medication
Yes ❑ No ❑ Allergies
Yes ❑ No ❑ Previous history of concussions
Yes ❑ No ❑ Fainting or seizure during or after physical activity
Yes ❑ No ❑ Near fainting or Brownouts
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 problem

Yes ❑ No ❑ Asthma
Yes ❑ No ❑ Trouble breathing during exercise
Yes ❑ No ❑ Heart Condition
Yes ❑ No ❑ Palpitations or Racing Heart
Yes ❑ No ❑ Family history of heart disease
Yes ❑ No ❑ Family history of unexpected death during physical activity
Yes ❑ No ❑ Family history of unexplained death of a young person
Yes ❑ 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 baseball team
Yes ❑ No ❑ Has had an illness that lasted more than a week and required medical attention in the past year
Yes ❑ No ❑ Has had injuries requiring medical attention in the past year
Yes ❑ No ❑ Been admitted to hospital in the last year
Yes ❑ No ❑ Surgery in the last year
Yes ❑ No ❑ Presently injured
Injured body part: _____
Yes ❑ No ❑ Vaccinations up to date
Date of last Tetanus Shot:_____
Yes ❑ No ❑ Hepatitis B vaccination

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 coach/management advised of any change in the above information as soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hospital 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, emergency contact) as deemed necessary.

Signature of Parent or Guardian: _____

Date: _____