

## Camrose Minor Baseball Association $_{\rm Box\,1033}$

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



## **Player Safety/Medical Information**

Yes No Allergies Yes No Heart Condition Yes No Fainting or seizure during or after	Player's Name:					Players Date of Birth:			
Emergency Contact Name & Phone Number:    Doctor's Name and Phone Number:	Pare	nt's l	Name(s):						
Emergency Contact Name & Phone Number:    Doctor's Name and Phone Number:	Addr	ess:							
Alberta Health Care#:    Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.    Yes	Home Phone: Cell#1:					Cell#	2: _		
Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.  Yes   No   Medication   Yes   No   Asthma   Yes   No   Health problem that would interfer participation on a baseball team participation on a baseball tea	Eme	rgeno	cy Contact Name & Phon	e Numbe	er: _				
Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.  Yes   No   Medication   Yes   No   Asthma   Yes   No   Asthma   Yes   No   Allergies   Yes   No   Trouble breathing during exercise   Yes   No   Has had an illness that tasted meta has have and required medicate attention in the pastyser   Yes   No   Palpitations or Racing Heart   Yes   No   Has had an illness that tasted meta has have and required medicate attention in the pastyser   Yes   No   Palpitations or Racing Heart   Yes   No   Has had injuries requiring medicate the physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Family history of unexpected death of a young person   Yes   No   Wears glasses   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Wears dental appliance   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Wears dental appliance   Yes   No   Wears detail appliance   Yes   No   Wears detail appliance   Yes   No   Wears details if you answered "Yes" to any of the above. (Use separate sheet if necessary)  Medical conditions:	Doct	or's l	Name and Phone Numbe	r:					
Yes   No   Medication   Yes   No   Asthma   Yes   No   Health problem that would interfer participation on a baseball team   Yes   No   Allergies   Yes   No   Trouble breathing during exercise   Yes   No   Heart Condition   Has had an illness that lasted may not be physical activity   Yes   No   Palpitations or Racing Heart physical activity   Yes   No   Family history of heart disease   Yes   No   Has had injuries requiring medication in the past year   Yes   No   Family history of unexpected death during physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Are lenses shatterproof   Yes   No   Wears dental appliance   Yes   No   Diabetes – Type 1   Type 2   Yes   No   Wears dental appliance   Yes   No   Wears medical information bracelet/necklace For what purpose?   Yes   No   Hearting problem   Yes   No   Hearting p	Albe	rta H	ealth Care#:						
Yes   No   Allergies   Yes   No   Trouble breathing during exercise   Yes   No   Hash ad an illness that lasted method in the past year   Yes   No   Heart Condition   Yes   No   Hash ad an illness that lasted method attention in the past year   Yes   No   Palpitations or Racing Heart   Yes   No   Hash ad an illness that lasted method attention in the past year   Yes   No   Family history of heart disease   Yes   No   Hash ad injuries requiring medic attention in the past year   Yes   No   Family history of unexpected death during physical activity   Yes   No   Are lenses shatterproof   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Wears contact lenses   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Hearing problem   Yes   No   Wears medical information bracelet/necklace   For what purpose?   Yes   No   Hepatitis B vaccination   Hepatitis B vaccination   Hepatitis B vaccination   Yes   No   Hepatitis B vaccinatio	Please	check t	ne appropriate response and provide	details belov	v if you	u answer "Yes" to any of the questions.			
Yes   No   Altergies   Yes   No   Trouble breathing during exercise   Yes   No   Has had an illness that Lasted much an aveck and required medical attention in the past year   Yes   No   Family history of heart disease   Yes   No   Has had an illness that Lasted much an aveck and required medical attention in the past year   Yes   No   Family history of heart disease   Yes   No   Has had an illness that Lasted much an aveck and required medical attention in the past year   Yes   No   Family history of heart disease   Yes   No   Has had injuries requiring medical attention in the past year   Yes   No   Family history of unexpected death during physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Family history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Previous history of unexpected death during physical activity   Yes   No   Prevently injured high part history of unexpected death during physical activity   Yes   No   Prevently injured high part	Yes 🗆	No 🗆	Medication	Yes □	No 🗆	Asthma	Yes 🗆	No 🗆	Health problem that would interfere with
Yes   No   Previous history of concussions   Yes   No   Heart Condition   than a week and required medica attention in the pastyear   Yes   No   Palpitations or Racing Heart   Yes   No   Has had riguries requiring medications in the past year   Yes   No   Pamily history of unexpected death   Agriculture   Yes   No   Been admitted to hospital in the law young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained death of a young person   Yes   No   Pamily history of unexplained history of unex	Yes 🗆	No 🗆	Allergies	Yes □	No 🗆	Trouble breathing during exercise			participation on a baseball team
Yes   No   Fainting or seizure during or after physical activity Yes   No   No   Family history of heart disease Yes   No   Near fainting or Brownouts Yes   No   Seizures and/or epilepsy Yes   No   Family history of unexpected death during physical activity Yes   No   Family history of unexpected death during physical activity Yes   No   Wears glasses Yes   No   Family history of unexpected death during physical activity Yes   No   Read activity Yes   No   Family history of unexpected death during physical activity Yes   No   Wears glasses Yes   No   Are lenses shatterproof Yes   No   Wears contact lenses Yes   No   Wears contact lenses Yes   No   Wears dental appliance Yes   No   Wears dental appliance Yes   No   Hearing problem Yes   No   Hearing problem  Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)  Medications:  Any information not covered above:  I understand that it is my responsibility to keep the team coach/management advised of any change in the above information soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Yes□	No □	Previous history of concussions	Yes □	No 🗆	Heart Condition	Yes 🗆	No 🗆	Has had an illness that lasted more than a week and required medical
Yes   No   Near fainting or Brownouts   Yes   No   Family history of heart disease   attention in the past year   Yes   No   Seizures and/or epilepsy   Yes   No   Family history of unexpected death during physical activity   Yes   No   Been admitted to hospital in the late year   Yes   No   Are lenses shatterproof   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Vears dental appliance   Yes   No   Wears dental appliance   Yes   No   Wears dental appliance   Yes   No   Wears medical information bracelet/necklace   Yes   No   Hearing problem   Yes   No   Hear	Yes □	No □	Fainting or seizure during or after	Yes □	No 🗆	Palpitations or Racing Heart			
Yes   No   Family history of unexpected death during physical activity   Yes   No   Been admitted to hospital in the late year a young person   Yes   No   Family history of unexpected death during physical activity   Yes   No   Surgery in the last year a young person   Yes   No   Family history of unexplained death of a young person   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Presently injured Injured body part:   Yes   No   Wears dental appliance   Yes   No   Wears dental appliance   Yes   No   Wears dental appliance   Yes   No   Wears medical information bracelet/necklace   Yes   No   Hepatitis B vaccination   Yes   No			physical activity	Yes □	No 🗆	Family history of heart disease	Yes □	No □	Has had injuries requiring medical
No   Setzures and/ or epitepsy   Couring physical activity   Ves   No   Setzures and/ or epitepsy   Ves   No   Family history of unexplained death of a young person   Ves   No   Presently injured   Injured body part:   Ves   No   Presently injured   Injured   Injured body part:   Ves   No   Presently injured   Injured   Injured   Injured   Injured   Injured   Injured   Injured	Yes □	No □	-	Yes □	No 🗆		Voc 🗆	No 🗆	
No   Wears guasses   No   Wears guasses   No   Are lenses shatterproof   Yes   No   Diabetes - Type 1   Type 2   Yes   No   Wears dental appliance   Yes   No   Hearing problem	Yes 🗆	No 🗆				3, 3			,
Yes   No   Are lenses shatterproof Yes   No   Wears contact lenses Yes   No   Wears dental appliance Yes   No   Hearing problem  Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)  Medications:	Yes □	No □	5	Yes □	No □				
Yes   No   Wears contact lenses Yes   No   Wears dental appliance Yes   No   Wears dental appliance Yes   No   Wears medical information bracelet/necklace For what purpose?   Yes   No   Wears dental appliance Yes   No   Hearing problem  Medications:   Recent injuries:   Any information not covered above:   Medical conditions:   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/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Yes □	No □	•	Yes □	No 🗆	,	163		
Yes   No   Hearing problem   Yes   No   Hepatitis B vaccination	Yes □	No 🗆					Yes □		
Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)  Medications:  Recent injuries:  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 soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people						For what purpose?			
Medications: Recent injuries: Any information not covered above: Medical conditions: 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 a soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Yes □	No □	Hearing problem				Yes □	No 🗆	Hepatitis B vaccination
Allergies:		e give	details if you allswered Tes	to any or t	ile au	ove. (ose separate sneet ii netes			
Medical conditions:  I understand that it is my responsibility to keep the team coach/management advised of any change in the above information a soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Medications:					Recent injuries:			
I understand that it is my responsibility to keep the team coach/management advised of any change in the above information a soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Allergi	es:				Any information not c	overed	above:	
soon as possible and that in the event no can be contacted, coaches or team management will take my child to MD/clinic/hosp deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child also authorize release of information to appropriate people	Medic	al cond	tions:						
Signature of Parent or Guardian:	soon a deem I here also a (coac	as pos ed nec eby aut uthori h, phys	sible and that in the event no essary. thorize the physician and nurs ze release of information to a sician, emergency contact) as	can be con sing staff t ppropriate deemed n	ntacto o uno e peop ecess	ed, coaches or team managemer dertake examination, investigation ple sary.	nt will t	ake m	y child to MD/clinic/hospital if