**PLAYER REGISTRATION FORM**

**FAIRVIEW MINOR HOCKEY ASSOCIATION MEDICAL FORM**

**PLAYER INFORMATION (Please Print)**

|  |  |  |
| --- | --- | --- |
| **LAST NAME** | **FIRST NAME** | **GENDER (CIRCLE)**  **F M** |
| STREET ADDRESS (NO PO BOX PLEASE) | TOWN | POSTAL CODE |
| MAILING ADDRESS  (IF DIFFERENT FROM STREET ADDRESS) | LEGAL LAND DESCRIPTION (IF APPLICABLE) | DATE OF BIRTH  / / .  MM DD YYYY |
| HOME PHONE | CELL PHONE | AB HEALTH CARE # |

**EMERGENCY CONTACT INFORMATION (PLEASE PRINT)**

|  |  |  |
| --- | --- | --- |
| LAST NAME | FIRST NAME | RELATIONSHIP TO PLAYER |
| HOME PHONE | WORK PHONE | CELL PHONE |
| FAMILY DOCTOR’S NAME | PHONE | DATE OF LAST PHYSICAL |
| FAMILY DENTIST’S NAME | PHONE | |

**PLEASE ADVISE YOUR COACH, TEAM MANAGER AND FMH EXECUTIVE OF ANY HEALTH RESTRICTIONS**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | | **YES** | **NO** | |
| 1. | Have you ever been hospitalized?....................................................................................................... | | | | | | | € | € | |
|  | Have you ever had surgery?................................................................................................................. | | | | | | | € | € | |
| 2. | Are presently taking any medications or pills?.................................................................................... | | | | | | | € | € | |
|  | Are presently taking any vitamins or supplements?........................................................................... | | | | | | | € | € | |
| 3. | Do you have any allergies? (medications, bees, etc)………………………………………………………………………. | | | | | | | € | € | |
|  | If yes, please list: . | | | | | | |  |  | |
| 4. | Have you ever passed out during or after exercising?......................................................................... | | | | | | | € | € | |
|  | Have you ever been dizzy during or after exercising? …………………………………………………………………… | | | | | | | € | € | |
|  | Have you ever had chest pain during or after exercising?................................................................... | | | | | | | € | € | |
|  | Do you tire more quickly than your friends during exercise?.............................................................. | | | | | | | € | € | |
|  | Have you ever had high blood pressure?............................................................................................. | | | | | | | € | € | |
|  | Have you ever been told that you have a heart murmer?................................................................... | | | | | | | € | € | |
|  | Have you ever had racing of your heart or skipped heart beats?........................................................ | | | | | | | € | € | |
|  | Has anyone in your family died of heart problems or sudden death before age 50?......................... | | | | | | | € | € | |
| 5. | Do you have any skin problems (itching, rashes or acne)? …………………………………………………………….. | | | | | | | € | € | |
| 6. | Have you ever had heat or muscle cramps?........................................................................................ | | | | | | | € | € | |
|  | Have you ever been dizzy or passed out in the heat? …………………………………………………………………….. | | | | | | | € | € | |
| 7. | Do you have trouble breathing or do you cough during or after activity? ………………………………………. | | | | | | | € | € | |
| 8. | Do you use any special equipment (pads, braces, eye guards, etc)? ………………………………………………. | | | | | | | € | € | |
|  | Do you use any dental appliances? ………………………………………………………………………………………………… | | | | | | | € | € | |
| 9. | Have you had any problems with your eyes or vision? ………………………………………………………………….. | | | | | | | € | € | |
|  | Do you wear eyeglasses, contacts or protective eye wear? ………………………………………………………….. | | | | | | | € | € | |
| 10. | Have you had any other medical problems (infectious mononucleosis, diabetes, etc)? …………………. | | | | | | | € | € | |
| 11. | Have you had a medical problem or injury since your last medical? ……………………………………………... | | | | | | | € | € | |
| 12. | Have you had any unexplained weight change? ……………………………………………………………………………. | | | | | | | € | € | |
|  |  | | | | | | |  |  | |
| 13. | When was your last tetanus shot? / / .  Month Day Year | | | | | | |  |  | |
| 14. | When was your last measles immunization? ? / / .  Month Day Year | | | | | | |  |  | |
| **HEAD INJURIES/ CONCUSSION** | | | | | | | |  |  | |
|  |  | | | | | | | **YES** | **NO** | |
| 15. | Have you ever had a seizure? ……………………………………………………………………………………………………….. | | | | | | | € | € | |
| 16. | Have you ever had a head injury? …………………………………………………………………………………………………. | | | | | | | € | € | |
|  | Have you ever had a concussion or been “knocked out”, “bell rung” or been “dinged”? ………………. | | | | | | | € | € | |
|  | If yes, please list: Number of occurrences: .  Date(s): .  Activity at time of injury: .  Length of Unconsciousness (minutes): .  Length of time before full return to activity: .  Did you have persistent problems with: Memory?.................................................................  Dizziness? ……………………………………………………………  Headaches? ………………………………………………………… | | | | | | |  |  | |
| **NECK INJURIES/ BURNERS/ STINGERS:** | | | | | | | |  |  | |
|  | | | | | | | | **YES** | **NO** | |
| 17. | Have you ever had a neck injury (ie strain, sprain, fracture, etc.)? ……………………………………………….. | | | | | | | € | € | |
| 18. | Have you ever had a stinger, burner or pinched nerve? ……………………………………………………………….. | | | | | | | € | € | |
|  | Have you ever had a burning or numb felleing in the shoulder or arm after a hit to the head, neck or shoulder (aka Brachial plexus stretch injury) | | | | | | | € | € | |
|  | If yes, please list: Number of occurrences: .  Date(s): .  Activity at time of injury: .  Length of sensation/ strength changes persisted .  Length of time before full return to activity: . | | | | | | |  |  | |
| Check any of the areas that you have INJURED IN THE PAST and explain the injury below | | | | | | | | | | |
| * Hand | | | | * Hip | * Arm | * Ankle | * Back | | |
| * Elbow | | | | * Shin/ Calf | * Chest | * Forearm | * Knee | | |
| * Neck | | | | * Wrist | * Thigh | * Shoulder | * Foot | | |
|  | | Year of injury: .  Type of injury: .  Side (Left/Right/Both): .  Length of time before full return to activity: . | | | | | |  |  | |
|  | |  | | | | | | **YES** | **NO** | |
|  | | Is it still a problem? ……………………………………………………………………………………………………………………… | | | | | | € | € | |
|  | | Explain injury: |  | | | | |  |  | |
|  | |  |  | | | | |  |  | |
|  | |  |  | | | | |  |  | |
|  | |  |  | | | | |  |  | |
|  | |  | | | | | | **YES** | **NO** | |
| 19. | | Do you have any incompletely healed injuries? ………………………………………………………………………… | | | | | | € | € | |
|  | | If yes, which injury? . | | | | | |  |  | |

**I hereby certify the above information to be correct.**

|  |  |  |
| --- | --- | --- |
| **PLAYER NAME (PRINT)** | **PLAYER SIGNATURE** | **DATE** |
| **PARENT NAME (PRINT)** | **PARENT SIGNATURE** | **DATE** |
| **PARENT NAME (PRINT)** | **PARENT SIGNATURE** | **DATE** |