

**MEDICAL INFORMATION SHEET**

Name: \_\_\_\_\_

Date of birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_ ) \_\_\_\_\_

Provincial Health Number (optional): \_\_\_\_\_

**Parent/Guardian #1:** Name \_\_\_\_\_

Business Phone Number: ( \_\_\_\_ ) \_\_\_\_\_

**Parent/Guardian #2:** Name \_\_\_\_\_

Business Phone Number: ( \_\_\_\_ ) \_\_\_\_\_

**Alternate emergency contact (if parents are not available)**

Name: \_\_\_\_\_

Relationship to Player: \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_ ) \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_

**Dentist's Name:** \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_

*Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician*

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

- |  |   |  |
|--|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Medication  | Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma   | Yes <input type="checkbox"/> No <input type="checkbox"/> Health problem that would interfere with participation on a hockey team                         |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Allergies   | Yes <input type="checkbox"/> No <input type="checkbox"/> Trouble breathing during exercise                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> Has had an illness that lasted more than a week and required medical attention in the past year |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Previous history of concussions                       | Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Condition  | Yes <input type="checkbox"/> No <input type="checkbox"/> Has had injuries requiring medical attention in the past year                                   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting or seizure during or after physical activity | Yes <input type="checkbox"/> No <input type="checkbox"/> Palpitations or Racing Heart   | Yes <input type="checkbox"/> No <input type="checkbox"/> Been admitted to hospital in the last year  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Near fainting or Brownouts                            | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of heart disease  | Yes <input type="checkbox"/> No <input type="checkbox"/> Surgery in the last year  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures and/or epilepsy                              | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of unexpected death during physical activity            | Yes <input type="checkbox"/> No <input type="checkbox"/> Presently injured<br>Injured body part: _____   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears glasses   | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of unexplained death of a young person                  | Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinations up to date<br>Date of last Tetanus Shot: _____                                     |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are lenses shatterproof                               | Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes - Type 1 _____ Type 2 _____                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis B vaccination   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears contact lenses                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> Wears medical information bracelet/necklace<br>For what purpose? _____ |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears dental appliance                                |   |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing problem                                       |   |  |

**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 Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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) as deemed necessary.

Date: \_\_\_\_\_ Signature of Player: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

*Disclaimer: Personal information used, disclosed, secured or retained by the soccer organization will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act .*