**PLAYER INFORMATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **Player's Name:** |        | Date of Birth: |        |
| Home Address: |        | Phone: |        |
| Email: |        | Date Form Completed: |        |

**Persons to be Contact in Case of Emergency**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mother's Name:** |        |   |  |  |  |  |
| Phone Numbers: | Day: |        | Evening: |        | Cell: |        |
|  |  |  |  |  |  |  |
| **Father's Name:** |        |   |  |  |  |  |
| Phone Numbers: | Day: |        | Evening: |        | Cell: |        |
|  |  |  |  |  |  |  |
| **Alternate Contact:** |        |   |  Relationship to Player: |        |   |
| Phone Numbers: | Day: |        | Evening: |        | Cell: |        |
|  |  |  |  |  |  |  |
| Family Doctor: |        |   |   |   | Phone: |        |
| Alberta Health Care #: |        |   |   |   |  |  |

**Relevant Medical History**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medications: |        |   |  | Allergies: |        |   |   |   |
| Previous Injuries: |        |   |   |   |   |   |   |   |
| Does the Player carry and know how to administer his/her own medication? | Yes |[ ]  No |[ ]  N/A |[ ]
| Has the Player ever had a concussion? | Yes [ ]  No [ ]  If so, how many? |        | Date of last concussion: |        |   |
| Other Conditions (braces, contact lenses, etc.) |        |   |   |   |   |   |   |
| **Parent's Signature** | X  |   |   |  | Date |       |