**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 | |  | | | |