PARTICIPANT INFORMATION FORM

Player`s Name: ________________________________ Birth Date: ____________________

Home Address: ________________________________ Phone No: ____________________

Email: ____ Date: ________________________

Persons to be Contacted in Case of Emergency:

Mother: _________________________________

Phone Nos.: Day: ______________________ Evening: __________________ Cell: _________________

Father: __________________________________

Phone Nos.: Day: ____________________ Evening: ___________________ Cell: _________________

Alternate Contact:

Phone Nos.: Day: ____________________ Evening: ___________________ Cell: _________________

Family Doctor: ____

Alberta Health Number: _______________________

Relevant Medical History

Medications: ____

Allergies: ____

Previous Injuries: ____

Does the Participant carry and know how to administer his or her own medications. Yes __ No __ NA ___

Has the Participant ever had a concussion. Yes ___ No ____ If so, how many __________ Date of Last Concussion: __________________

Other Conditions (braces, contact lenses, seizures etc.) ____

Parent`s Signature: ____

Date: ____