Kitchener Ringette Association

Medical Information Form

Child and Parent Information

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Child's Name | **Date of Birth** | **Sex**

Parent's/Guardian's Name | **Parent's/Guardian's Name**

Home Phone | **Work Phone** | **Home Phone** | **Work Phone**

Address | **Address**

City, Province, Postal Code | **City, Province, Postal Code**

Alternative Emergency Contacts (If parents not available)

Primary Emergency Contact | **Secondary Emergency Contact**

Home Phone | **Work Phone** | **Home Phone** | **Work Phone**

Address | **Address**

City, Province, Postal Code | **City, Province, Postal Code**

Medical Information

Physician's Name | **Phone Number**

Dentist's Name | **Phone Number**

Date of last complete physical Examination

*** Before a player participates in a ringette program, any medical condition or injury problem should be checked by that individual's family physician**

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Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions:

Yes	No	Previous history of concussion
Yes	No	Fainting episodes during exercise
Yes	No	Epileptic
Yes	No	Wear glasses - If yes, are lens shatter proof: YES NO
Yes	No	Wear contact lenses
Yes	No	Wear dental appliance
Yes	No	Hearing problem
Yes	No	Asthma
Yes	No	Trouble breathing during exercise
Yes	No	Heart Condition
Yes	No	Diabetic – If yes circle the applicable: Type 1 Type 2
Yes	No	Medications If yes, please list: _____
Yes	No	Wears a medical information bracelet or necklace.
		If yes, for what purpose? _____
Yes	No	Allergies If yes, please list _____
Yes	No	Has any health problem that would interfere with participation on a ringette team
Yes	No	Has had an illness that lasted more than a week & required medical attention in the past year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Surgery in the last year
Yes	No	Presently injured. Injured body part If yes, what is the injury _____
Yes	No	GIRLS ONLY: Has your daughter started her menstrual cycle? If not is she informed? Yes No
Yes	No	Vaccinations up to date Date of last tetanus shot:_____

Health Card Number:_____

Any information or medical conditions not covered above:

_____

_____

I understand that it is my responsibility to keep the team Trainer 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 Parent/Guardian:_____

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