



**MEDICAL INFORMATION SHEET**

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

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

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

Postal Code: \_\_\_\_\_ Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_\_ ) \_\_\_\_\_

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

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Business Telephone Numbers: Parent \_\_\_\_\_ Parent \_\_\_\_\_

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, any medical condition or injury problem should be checked by that individual's family physician.

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

- Yes No Medication
- Yes No Allergies
- Yes No Previous history of concussions
- Yes No Fainting episodes during exercise
- Yes No Seizures and/or epilepsy
- Yes No Wears glasses
- Yes No Are lenses shatterproof
- Yes No Wears contact lenses
- Yes No Wears dental appliance
- Yes No Hearing problem
- Yes No Asthma
- Yes No Trouble breathing during exercise
- Yes No Heart Condition
- Yes No Family history of heart disease
- Yes No Diabetes – Type 1 \_\_\_\_\_ Type 2 \_\_\_\_\_



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

- Yes No Wears a medical information bracelet or necklace  
For what purpose? \_\_\_\_\_
- Yes No Has any health problem that would interfere with participation on a hockey team
- Yes No Has had an illness that lasted more than a week and required medical attention in the past year
- Yes No Has had injuries requiring medical attention in the past year
- Yes No Has been admitted to hospital in the last year
- Yes No Surgery in the last year
- Yes No Presently injured. Injured body part: \_\_\_\_\_
- Yes No Vaccinations up to date  
Date of last Tetanus Shot: \_\_\_\_\_
- Yes No Hepatitis B vaccination

**Please give details if you answered "Yes" to any of the above. Use separate sheet if necessary**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical conditions: \_\_\_\_\_

Recent injuries: \_\_\_\_\_

Any information not covered above: \_\_\_\_\_

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: \_\_\_\_\_

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