Medicine Hat Lacrosse Club
Player Medical Information Sheet

PLAYER INFORMATION

Name: _____ **DOB:** _____
LEGAL GIVEN NAME MONTH/DAY/YEAR

Address: _____
STREET, CITY, PROVINCE, POSTAL CODE

Alberta Health Care Number: _____

Parent / Guardian Contact #1
Name:_____ **Cell:**_____**Alt:** _____

Address: _____
STREET, CITY, PROVINCE, POSTAL CODE IF DIFFERENT FROM ABOVE

Parent / Guardian Contact #2
Name:_____ **Cell:**_____**Alt:** _____

Address: _____
STREET, CITY, PROVINCE, POSTAL CODE IF DIFFERENT FROM ABOVE

Alternative Contact: (in the event the above contacts are not available)
Name:_____ **Cell:**_____**Alt:** _____

Address: _____
STREET, CITY, PROVINCE, POSTAL CODE

MEDICAL INFORMATION

Doctor's Name:_____ **Phone:** _____

Dentist's Name:_____ **Phone:** _____

Please check the appropriate response pertaining to the below

Medical History	Yes	No
Previous history of concussions?		
Fainting episodes during exercise?		
Epileptic?		
Wears glasses?		
Are lenses shatterproof?		
Wears dental appliance?		
Hearing problem?		
Asthma?		
Trouble breathing during exercise?		
Heart Condition?		
Diabetic?		
Has had an illness lasting more than a week in the past year?		
Medication?		

This form to be destroyed by the Manager at the end of the season

Medicine Hat Lacrosse Club
Player Medical Information Sheet

Medical History	Yes	No
Allergies?		
Does your child have any health problem that would interfere with participation on a lacrosse team?		
Surgery in the last year?		
Has been in hospital in the last year?		
Has had injuries requiring medical attention in the past year?		
Presently inured?		

If you entered YES to any of the above questions, please provide details below:

_____

_____

_____

_____

_____

Medication: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Last Tetanus Shot: _____

Any other relevant information:

_____

_____

_____

Date of last physical exam: _____

****Any medical condition or injury should be checked by your physician prior to participating in a lacrosse program****

I understand that it is my responsibility to keep the team management advised of any changes in the above information as soon as possible. In the event no one can be contacted, team management can take my child to the hospital/M.D. if necessary.
I hereby authorize first responders, physicians, and nursing staff to undertake examination investigation and necessary treatment of my child.
I also authorize the release of information to appropriate individuals (first responders, doctors, hospital staff) as deemed necessary.

Signature of Parent/Guardian: _____ **Date:** _____

This form to be destroyed by the Manager at the end of the season