**PLAYER MEDICAL INFORMATION SHEET**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Player’s Name:** |  | | | | |
| **Date of Birth:** |  | **Health Card:** | |  | |
| **Address:** |  | | | | |
| **Phone #:** |  | **Cell Phone #:** | |  | |
| **Email:** |  | | | | |
| **Parent/Guardian Information:** | | | | | |
| **Name:** |  | | **Living with Player:** | |  |
| **Business Phone:** |  | **Cell Phone #:** | |  | |
| **Email:** |  | | | | |
| **Name:** |  | | **Living with Player:** | |  |
| **Business Phone:** |  | **Cell Phone #:** | |  | |
| **Email:** |  | | | | |
| **Emergency Contact:**  **(if parent/guardian is not available)** | | | | | |
| **Name:** |  | **Phone #:** | |  | |
| **Relationship:** |  |  | |  | |
| **Name:** |  | **Phone #:** | |  | |
| **Relationship:** |  |  | |  | |
| **Doctor:** |  | **Phone:** | |  | |
| **Dentist:** |  | **Phone:** | |  | |

**Please circle the appropriate response below pertaining to your child.**

|  |  |  |
| --- | --- | --- |
| Yes | No | Previous history of concussions |
| Yes | No | Fainting episodes during exercise |
| Yes | No | Epileptic |
| Yes | No | Wears glasses |
| Yes | No | If yes to above, are lenses shatterproof? |
| Yes | No | Wears dental appliance |
| Yes | No | Hearing problem |
| Yes | No | Asthma |
| Yes | No | Trouble breathing during exercise |
| Yes | No | Heart condition |
| Yes | No | Diabetic |
| Yes | No | Has had an illness lasting more than a week in the past year |
| Yes | No | Medication |
| Yes | No | Allergies |
| Yes | No | Wears a medical alert bracelet or necklace |
| Yes | No | Does your child have any health problem that would interfere in the participation on a basketball team? |
| Yes | No | Surgery in the last year |
| Yes | No | Has been hospitalized in the last year |
| Yes | No | Has had injuries requiring medical attention in the last year |
| Yes | No | Presently injured |

**Please give details below if you answered “Yes” to any of the above items.**

|  |  |
| --- | --- |
| **Medications:** |  |
| **Allergies:** |  |
| **Medical Conditions:** |  |
| **Recent Injuries:** |  |
| **Any information not covered above:** |  |
| **Date of last complete physical examination:** |  |

I understand that it is my responsibility to keep the team management advised of any changes in the above information as soon as possible and that in the event no one can be contacted; team management will take my child to the hospital if deemed necessary.

I hereby authorize the physician or nursing staff to undertake the examination, investigation, and necessary treatment of my child.

I also authorize release of information to appropriate medical staff people (physician, nurses, paramedics, etc.) as deemed necessary.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent