Okotoks Minor Hockey Association

"Practice and play like a champion today!"

Box 1152 Okotoks, AB T1S 1B2

403.710-2213

PLAYERS MEDICAL INFORMATION FORM

Name _____ Date of Birth: Day ____Month _____ Year_____

Address: _____ Postal Code: _____

Telephone: _____ **Provincial Health Care Number:** _____

Parent/Guardian Contact Information:

Mother's Name: _____ Father's Name: _____

Mother's Phone: _____ Father's Phone: _____

Person to contact in case of accident or emergency, if parents are not available:

Name: _____ Telephone: _____

Address: _____

Doctor Information:

Doctor's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

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 Are lenses shatterproof

☐Yes ☐No Wears contact lenses

☐Yes ☐No Wears dental appliance

☐Yes ☐No Hearing problem

Okotoks Minor Hockey Association

"Practice and play like a champion today!"

Box 1152 Okotoks, AB T1S 1B2

403.710-2213

☐Yes ☐No Asthma

☐Yes ☐No Trouble breathing during exercise

☐Yes ☐No Has had an illness lasting more than a week in the past year

☐Yes ☐No Medication: _____

☐Yes ☐No Allergies: _____

☐Yes ☐No Does your child have any health problem that would interfere with participation on a hockey team

☐Yes ☐No Surgery in the last year

☐Yes ☐No Has been in hospital in the last year

☐Yes ☐No Has had injuries requiring medical attention in the past year

☐Yes ☐No Presently injured

☐Yes ☐No Heart Condition

☐Yes ☐No Diabetic

Please use a separate sheet to provide additional information regarding Medication and Allergies, if necessary. Please give additional details below if you answered "Yes" to any of the above items and needed

Medical Conditions: _____

Recent Injuries: _____

Last Tetanus Shot: _____

Any information not covered above: _____

Date of last complete physical examination: _____

Any medical condition or injury problem should be checked by your physician before participating in a hockey program.

I understand that it is my responsibility to keep the team management advised of any change 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 hospital/M.D. if deemed necessary. I hereby authorize the physician and nursing staff to undertake an examination investigation and necessary treatment of my child.

I also authorize release of information to appropriate people (coach, physician) deemed necessary.

Date: _____ Signature of Parent or Guardian: _____