



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 Oilers Athletic Association

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Box 954 Okotoks, AB T1S 1B1

- 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: _____