



Paris Ringette Association Medical Release Form

Players Name: _____
 Date of Birth: Day _____ Month _____ Year _____
 Address: _____ City: _____
 Postal Code: _____ Home Phone Number: _____

Parent/Guardian	Work Number	Cellular number

Person to contact in case of accident or emergency should parents not be available

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Child's Doctor: _____ Phone: _____

Child's Dentist: Phone: _____

Known Allergies: _____

(Include medicine, food, bee stings, etc.)

Current Medications: _____

Please circle the appropriate responses below pertaining to your child

- | | | | | |
|-----|----|--|-------------------------------------|--------|
| Yes | No | Previous history of concussions | | |
| Yes | No | Fainting episodes during exercise | | |
| Yes | No | Epileptic | | |
| Yes | No | Wears Glasses | *if yes are the lenses shatterproof | Yes No |
| Yes | No | Wears Contact lenses | | |
| Yes | No | Wears dental appliances | | |
| Yes | No | Hearing problems | | |
| Yes | No | Asthma | | |
| Yes | No | Trouble breathing during exercise | | |
| Yes | No | Heart Condition | | |
| Yes | No | Diabetic or other sugar regulation problems | | |
| Yes | No | Has had an illness lasting more than a week in the past year | | |
| Yes | No | Wears a medic alert bracelet or necklace | | |
| Yes | No | Surgery in the last year | | |
| Yes | No | Hospital admission in the past year | | |
| Yes | No | Injury that required medical attention in the past year | | |
| Yes | No | Presently injured | | |

If you answered yes to any of the previous questions or have any not covered conditions, please give details below

Medical Release

I hereby permit my child to participate in the Paris Ringette Association Ringette Season 2022/2023

I understand and fully accept that there are risks involved in sports and that accident and injuries are common and are ordinary occurrences of sports.

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 / clinic if deemed necessary. I also authorize release of information to appropriate people (coaching staff, hospital/clinic, EMT)

I understand that every attempt will be made to reach a parent or guardian by phone / email at the earliest opportunity. I also understand that all medical costs are my responsibility.

Parent or Guardian Signature: _____

Date: _____