Paris Ringette Association Medical Release Form

Players Name: _____
Date of Birth (Day/Month/Year) _____
Address: _____
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 Number: _____
Relationship: _____

Players Doctor: _____
Phone Number: _____
Players Dentist: _____
Phone Number: _____
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

_____
_____
_____

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Medical Release

I hereby permit my child to participate in the Paris Ringette Association Ringette Season 2025/2026

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: _____