**Rockyford Minor Hockey & Ringette**

**Player Medical Information Sheet**

Name: Click here to enter text.

Date of birth: Click here to enter a date.

Address: Click here to enter text.

City: Click here to enter text. Postal Code: Click here to enter text.

Telephone: Click here to enter text.

Provincial Health Number: Click here to enter text.

Mother’s Name: Click here to enter text. Father’s Name: Click here to enter text.

Cellphone Numbers: Mother’s Click here to enter text. Father’s Click here to enter text.

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

Name: Click here to enter text.

Telephone: Click here to enter text.

Address:

City: Click here to enter text. Postal Code: Click here to enter text.

Doctor’s Name: Click here to enter text. Telephone: Click here to enter text.

Dentist’s Name: Click here to enter text. Telephone: Click here to enter text.

**Please check the appropriate response below pertaining to you child**

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 ☐Yes ☐No

Asthma ☐Yes ☐ No

Trouble breathing during exercise ☐Yes ☐ No

Heart Condition ☐Yes ☐No

Diabetic ☐Yes ☐No

Medication ☐Yes ☐No

Allergies ☐Yes ☐No

Has medic alert bracelet or necklace ☐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

Had injuries requiring medical attention in the past year ☐Yes ☐ No

Presently injured ☐Yes ☐No

Please give details below if you answered “Yes” to any of the above items. Click here to enter text.

Medications: Click here to enter text.

Allergies: Click here to enter text.

Medical conditions: Click here to enter text.

Recent Injuries: Click here to enter text.

Last Tetanus Shot: Click here to enter text.

Any information not covered above: Click here to enter text.

\* 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 examination investigation and necessary treatment of my child.

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

Date: Click here to enter a date. Signature of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_