



PARTICIPANT INFORMATION FORM

Player's Name: _____ Birth Date: _____

Home Address: _____ Phone No: _____

Email: _____ Date: _____

Persons to be Contacted in Case of Emergency:

Mother: _____

Phone Nos.: Day: _____ Evening: _____ Cell: _____

Father: _____

Phone Nos.: Day: _____ Evening: _____ Cell: _____

Alternate Contact:

Phone Nos.: Day: _____ Evening: _____ Cell: _____

Family Doctor: _____

Alberta Health Number: _____

Relevant Medical History

Medications: _____

Allergies: _____

Previous Injuries: _____

Does the Participant carry and know how to administer his or her own medications. Yes ___ No ___ NA ___

Has the Participant ever had a concussion. Yes ___ No ___ If so, how many _____ Date of Last Concussion: _____

Other Conditions (braces, contact lenses, seizures etc.) _____

Parent's Signature: _____

Date: _____

