



MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number (optional): _____

Parent/Guardian #1: Name _____

Business Phone Number: (____) _____

Parent/Guardian #2: Name _____

Business Phone Number: (____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Telephone: (____) _____

Dentist's Name: _____

Telephone: (____) _____

Date of last complete physical examination: _____

Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes	No	Medication	Yes	No	Asthma	Yes	No	Health problem that would interfere with participation on a hockey team
Yes	No	Allergies	Yes	No	Trouble breathing during exercise	Yes	No	Has had an illness that lasted more than a week and required medical attention in the past year
Yes	No	Previous history of concussions	Yes	No	Heart Condition	Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Fainting or seizure during or after physical activity	Yes	No	Palpitations or Racing Heart	Yes	No	Has had hospital in the last year
Yes	No	Near fainting or Brownouts	Yes	No	Family history of heart disease	Yes	No	Been admitted to hospital in the last year
Yes	No	Seizures and/or epilepsy	Yes	No	Family history of unexpected death during physical activity	Yes	No	Surgery in the last year
Yes	No	Wears glasses	Yes	No	Family history of unexplained death of a young person	Yes	No	Presently injured Injured body part: _____
Yes	No	Are lenses shatterproof	Yes	No	Diabetes – Type 1 _____ Type 2 _____	Yes	No	Vaccinations up to date Date of last Tetanus Shot: _____
Yes	No	Wears contact lenses	Yes	No	Wears medical information bracelet/necklace For what purpose? _____	Yes	No	Hepatitis B vaccination
Yes	No	Wears dental appliance						
Yes	No	Hearing problem						

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

Medications: _____

Recent injuries: _____

Allergies: _____

Any information not covered above: _____

Medical conditions: _____

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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: _____ Signature of Player: _____

Date: _____ Signature of Parent or Guardian: _____

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