St.Marys Ringette Player Medical Information Sheet

Updated Aug 19 2020

Name: _____

Date of Birth: Day_____ Month_____ Year_____

Address: _____

Postal Code: _____ Telephone: _____

Provincial Health Number: _____

Mother's Name: _____ Father's Name: _____

Business Telephone Numbers: Mother _____Father_____

Person to contact in case of emergency, if parents not available:

Name: _____ Telephone: _____

Address: _____

Doctor's Name: _____ Telephone: _____

Dentist's name: _____ Telephone: _____

Allergies (medications, foods, etc): _____

_____

Medical conditions (Asthma, Diabetes, Epilepsy, etc):

Medications (name and dosage):_____

_____

Recent injuries: _____

_____

Last Tetanus Shot: _____

Date of last complete physical examination: _____

Please note this form is intended to be a communication tool between the player, parent and bench staff.

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Please circle the appropriate response below pertaining to your child:

Yes	No	Previous history of concussions?
Yes	No	Fainting episodes during exercise?
Yes	No	Wears glasses?
Yes	No	Wears contact lenses?
Yes	No	Wears dental appliance?
Yes	No	Hearing problem?
Yes	No	Trouble breathing during exercise?
Yes	No	Heart condition?
Yes	No	Wears a medic alert bracelet or necklace?
Yes	No	Surgery in the last year?
Yes	No	Has been in the hospital in the last year?
Yes	No	Has had injuries requiring medical attention in the past year?
Yes	No	Does your child have any health problem that would interfere with participation on a Ringette team?

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

Any other info not covered above: _____

_____

_____

Any medical condition or injury problem should be checked by your physician before participating in a Ringette 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 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.

I am aware of that the at-risk population for COVID includes anyone with compromised immune systems, older individuals 65+, those with co-existing medical conditions including but not limited to diabetes, cardiac disease, severe asthma, chronic lung conditions and auto-immune diseases.

Signature of Parent or Guardian: Date:

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