TABER LACROSSE ASSOCIATION
PLAYER MEDICAL INFORMATION SHEET

PLAYER NAME:	
DATE OF BIRTH (MM/DD/YYYY)	
STREET ADDRESS:	
CITY, PROVINCE:	
POSTAL CODE:	
ALBERTA HEALTH CARE #:	
HOME PHONE NUMBER:	
CELL PHONE #:	

MOTHER'S NAME:		**HOME PHONE #:**	
		CELL PHONE #:	
FATHER'S NAME:		**HOME PHONE #:**	
		CELL PHONE #:	

PERSON TO CONTACT IN CASE OF EMERGENCY (IF PARENTS ARE NOT AVAILABLE):	
CONTACT NAME:	
RELATIONSHIP TO PLAYER:	
ADDRESS	
HOME PHONE #:	
CELL PHONE #:	

DOCTOR'S NAME:		**OFFICE PHONE #:**	
DENTIST'S NAME:		**OFFICE PHONE #:**	

PLEASE CIRCLE THE APPROPRIATE RESPONSE PERTAINING TO THE PLAYER:

☐Yes ☐No	**Is the player currently injured?**
☐Yes ☐No	**Does the player have a history of concussions?**
☐Yes ☐No	**Has the player had surgery in the past year?**
☐Yes ☐No	**Has the player been in the hospital in the past year?**
☐Yes ☐No	**Has the player ever experienced fainting episodes during exercise?**
☐Yes ☐No	**Does the player have Asthma?**
☐Yes ☐No	**Does the player have Diabetes?**
☐Yes ☐No	**Does the player have a heart Condition?**
☐Yes ☐No	**Does the player have Epilepsy?**
☐Yes ☐No	**Does the player wear a dental appliance?**
☐Yes ☐No	**Does the player currently take any medication?**
☐Yes ☐No	**Does the player have trouble breathing during exercise?**
☐Yes ☐No	**Does the player have a hearing impairment?**
☐Yes ☐No	**Does the player wear prescription glasses?**
☐Yes ☐No	**Has the player had any injuries requiring medical attention in the past year?**
☐Yes ☐No	**Has the player had an illness lasting more than a week in the past year?**
☐Yes ☐No	**Does the player have any health problems that would interfere with participation on a lacrosse team?**

Please provide details if you answered "Yes" to any of the questions above:

(Use a separate sheet if necessary)

Medications:

Allergies:

Medical Conditions:

Date of Last Tetanus Shot:

Recent Injuries:

Date of Last Physical Examination:

Any additional information not covered above:

ANY MEDICAL CONDITION OR INJURY SHOULD BE CHECKED BY YOUR PHYSICIAN PRIOR TO PARTICIPATING IN A LACROSSE 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 the designated contacts cannot be contacted, team management will take my child to the hospital/medical facility, if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and any necessary treatment of my child.

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

Parent/Guardian Name and Signature	**Date**