UOV PLAYER MEDICAL INFORMATION FORM

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: _____

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

Business Telephone Numbers: Mother _____ Father _____

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

Name: _____Telephone: _____

Address: _____

Doctor's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

Please circle the appropriate response below pertaining to your child

Yes/No 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 Has had an illness lasting more than a week in the past year

Yes/No Medication

Yes/No Allergies

Yes/No Wears a medic alert bracelet or necklace.

Yes/No Does your child have any health problem that would interfere with participation on a ringette team?

Yes/No Surgery in the last year.

Yes/No Has been in hospital in the last year.

Yes/No Has had injuries requiring medical attention in the past year.

Yes/No Presently injured.

Please give details below if you answered "Yes" to any of the above items:

_____
_____
_____
_____

Medications:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

Medical conditions:

_____
_____
_____
_____

Recent Injuries:

_____
_____
_____
_____

Date of last Tetanus Shot:

_____

Any information not covered above:

_____

_____

_____

_____

_____

Date of last complete physical examination:

_____

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 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: _____ Signature of Parent or Guardian: _____