

## MEDICAL INFORMATION SHEET

Name:					Alternate emergency conta	Alternate emergency contact (if parents are not available)		
Date of birth: Day Month Year					Name:	Name:		
Address:					Relationship to Player:	Relationship to Player:		
					, , ,	Telephone: ( ) Cell: ( )		
Postal Code:					Doctor's Name:	Doctor's Name:		
Telephone: ( ) Cell: ( )					Telephone: (	Telephone: ()		
Provincial Health Number (optional):					Dentist's Name:	Dentist's Name:		
Parent/Guardian #1: Name					Telephone: (	Telephone: ()		
Business Phone Number:( )					Date of last complete physic	Date of last complete physical examination:		
Parent/Guardian #2: Name						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		
	, caura	Business Phone Number:(			medical and that they also no	ave any medica	l condition or injury problem checked by	
Please	check t	he appropriate response and provide	details bel	ow if yo	u answer "Yes" to any of the questions.			
Yes □	No □	Medication	Yes □	No □	Asthma	Yes □ No □		
Yes □	No □	Allergies	Yes □	No 🗆	Trouble breathing during exercise	Yes□ No□	participation on a hockey team  Has had an illness that lasted more	
Yes □	No □	Previous history of concussions	Yes □	No 🗆	Heart Condition	les 🗆 No 🗆	than a week and required medical	
Yes 🗆	No 🗆	Fainting or seizure during or after physical activity	Yes 🗆	No 🗆	Palpitations or Racing Heart	Yes□ No□	attention in the past year  Has had injuries requiring medical	
Yes□	No □	Near fainting or Brownouts	Yes □	No 🗆	Family history of heart disease	les di No d	attention in the past year	
Yes □	No □	Seizures and/or epilepsy	Yes □	No 🗆	Family history of unexpected death during physical activity	Yes □ No □	Been admitted to hospital in the last year	
Yes 🗆	No □	Wears glasses	Yes □	No 🗆	Family history of unexplained death of	Yes□ No□	Surgery in the last year	
Yes 🗆	No 🗆	Are lenses shatterproof			a young person		Presently injured red body part:	
Yes 🗆	No 🗆	Wears contact lenses	Yes 🗆	No 🗆	Diabetes – Type 1 Type 2	_	Vaccinations up to date	
Yes□	No □	Wears dental appliance	Yes 🗆	No 🗆	Wears medical information bracelet/necklace For what purpose?	Date of last Tetanus Shot:		
Yes 🗆	No □	Hearing problem				Yes □ No □	Hepatitis B vaccination	
		details if you answered "Yes" to any						
Medications:					<u> </u>	Any information not covered above:		
Allergies:					Any information not cove	red above:		
Med	ical con	ditions:			<u> </u>			
emerge physici (coach,	ency and an and i , physici	that no one can be contacted, team r nursing staff to undertake examinatio an) as deemed necessary.	nanagement n, investigat	will arra	dvised of any change in the above informa ange to take my child to the hospital or a p necessary treatment of my child. I also au	ohysician if dee thorize releas	emed necessary. I hereby authorize the	
Date: Signature of Player:								
					dian:			
					ckey Canada will be held solely for the purpon n and Electronic Documents Act as well as H			

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