



WEST OTTAWA RINGETTE ASSOCIATION

Season: _____

MEDICAL FORM

Please note: This form is intended to be a communication tool between the player, parent & bench staff.

Player:

Name: _____ Date of Birth: _____
(dd/mm/yyyy)
 Telephone: _____

Player's Mother/Legal Guardian:

Name: _____ Work Number: _____
 Cell Number: _____

Player's Father/Legal Guardian:

Name: _____ Work Number: _____
 Cell Number: _____

Alternate Emergency Contact (if parents/legal guardian not available):

Name: _____ Work Number: _____
 Relationship to Player: _____ Cell Number: _____

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

Yes	No	Previous history of concussions
Yes	No	Fainting episodes during exercise
Yes	No	Epileptic
Yes	No	Wears glasses. If yes, are lenses shatterproof: Yes No
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 -- Type 1 _____ Type 2 _____
Yes	No	Medication
Yes	No	Allergies
Yes	No	Wears a medical information bracelet or necklace. If yes, for what purpose?:
Yes	No	Any health problem that would interfere with participation on a ringette team (see next page)?



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

Medications: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Any information not covered above: _____

For your information, a female member of your team's bench staff will always be on the bench during games.

Please sign and date this form and return it to your team manager as soon as possible.

Signature: _____ Date: _____

Name (printed): _____