

## MEDICAL INFORMATION SHEET

Name:						Alternate emergency contact (if parents are not available)			
Date of birth: Day Month Year						Name:			
Address:						Relationship to Player:			
						Telephone: ( ) Cell: ( )			
Postal Code:						Doctor's Name:			
Telephone: ( ) Cell: ( )						Telephone: ( )			
Provincial Health Number (optional):						Dentist's Name:			
Parent/Guardian #1: Name						Telephone: ( )			
Business Phone Number:( )						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 their family physician			
Business Phone Number:( )									
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□	Health problem that would interfere with participation on a hockey team	
Yes □	No □	Allergies	Yes □	No □	Trouble breathing during exercise		Yes □ No □	•	
Yes 🗆	No □	Previous history of concussions	Yes □	No 🗆	Heart Co		1652 1102	than a week and required medical attention in the past year	
Yes □	No □	Fainting or seizure during or after physical activity	Yes □ Yes □	No □ No □		ions or Racing Heart istory of heart disease	Yes 🗆 No 🗆	Has had injuries requiring medical	
Yes □	No □	Near fainting or Brownouts	Yes□	No □	•	istory of unexpected death	Vac D. Na D.	attention in the past year	
Yes □	No □	Seizures and/or epilepsy				hysical activity	Yes No No	Been admitted to hospital in the last year Surgery in the last year	
Yes 🗆	No □	Wears glasses	Yes □	No 🗆	Family history of unexplained death of a young person			Presently injured	
Yes 🗆	No 🗆	Are lenses shatterproof	Yes □	No 🗆		s – Type 1 Type 2		d body part:	
Yes □ Yes □	No □ No □	Wears contact lenses Wears dental appliance	Yes 🗆	No 🗆		dical information bracelet/necklace		1 Vaccinations up to date of last Tetanus Shot:	
Yes 🗆	No □	Hearing problem			TOT WITA	. purpose	Yes□ No□	Hepatitis B vaccination	
Plea	se give	details if you answered "Yes" to any	of the abov	re. (Use	separate	sheet if necessary)			
Medications:						Recent injuries:			
Allergies:						Any information not covered above:			
Medical conditions:									
emerge physici (coach,	ency and an and i physici	nursing staff to undertake examinatio an) as deemed necessary.	nanagement n, investiga	will arr tion and	ange to ta necessary	ke my child to the hospital or a p y treatment of my child. I also aut	hysician if deer thorize release	ned necessary. I hereby authorize the	
Date: Signature of Player:									
Date: Signature of Parent or Guardian:									
		sonal information used, disclosed, secu y Principles contained in the Personal I						e collected it and in accordance with the own Privacy Policy.	