



PLAYER MEDICAL / INFORMATION SHEET

Category (please circle one)

Male U14 U15 U16

Female U14 U16 U18

Name: _____ Date of Birth: _____
Day Month Year

Mailing Address: _____

Hometown: _____

Province: _____ Postal Code: _____ Telephone (h): _____

***Email:** _____ Telephone (o): _____

Secondary Email: _____

Provincial Health Number: _____ 2024 School Grade: _____

Height: _____ Weight: _____ Shot: _____ Current Team: _____

Position: (please circle) G D F

Parent/ Guardian Name: _____ Business Phone Number: _____

Parent/ Guardian Name: _____ Business Phone Number: _____

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 hockey 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.

Use separate sheet if necessary

Allergies:

Food Allergies:

Food Intolerances:

Medications:

Medical Conditions:

Recent Injuries:

Last Tetanus Shot:

Date of Last Physical:

Any information not covered above:

Any medical condition or injury problem should be checked by your physician before participating in a hockey 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/MD if deemed necessary.

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

I also authorized release of information to appropriate people (coach, physician) as deemed necessary.

Date:

Signature of Parent or Guardian: