



**MEDICAL INFORMATION SHEET**

Name: \_\_\_\_\_  
 Date of birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_ ) \_\_\_\_\_  
 Provincial Health Number (optional): \_\_\_\_\_  
**Parent/Guardian #1:** Name \_\_\_\_\_  
 Business Phone Number:( \_\_\_\_ ) \_\_\_\_\_  
**Parent/Guardian #2:** Name \_\_\_\_\_  
 Business Phone Number:( \_\_\_\_ ) \_\_\_\_\_

**Alternate emergency contact (if parents are not available)**  
 Name: \_\_\_\_\_  
 Relationship to Player: \_\_\_\_\_  
 Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_ ) \_\_\_\_\_  
**Doctor's Name:** \_\_\_\_\_  
 Telephone: ( \_\_\_\_ ) \_\_\_\_\_  
**Dentist's Name:** \_\_\_\_\_  
 Telephone: ( \_\_\_\_ ) \_\_\_\_\_  
 Date of last complete physical examination: \_\_\_\_\_  
*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*

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

- |  |   |  |
|--|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Medication  | Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma   | Yes <input type="checkbox"/> No <input type="checkbox"/> Health problem that would interfere with participation on a hockey team                         |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Allergies   | Yes <input type="checkbox"/> No <input type="checkbox"/> Trouble breathing during exercise                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> Has had an illness that lasted more than a week and required medical attention in the past year |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Previous history of concussions                       | Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Condition  | Yes <input type="checkbox"/> No <input type="checkbox"/> Has had injuries requiring medical attention in the past year                                   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting or seizure during or after physical activity | Yes <input type="checkbox"/> No <input type="checkbox"/> Palpitations or Racing Heart   | Yes <input type="checkbox"/> No <input type="checkbox"/> Been admitted to hospital in the last year  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Near fainting or Brownouts                            | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of heart disease  | Yes <input type="checkbox"/> No <input type="checkbox"/> Surgery in the last year  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures and/or epilepsy                              | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of unexpected death during physical activity            | Yes <input type="checkbox"/> No <input type="checkbox"/> Presently injured<br>Injured body part: _____   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears glasses   | Yes <input type="checkbox"/> No <input type="checkbox"/> Family history of unexplained death of a young person                  | Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinations up to date<br>Date of last Tetanus Shot: _____                                     |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are lenses shatterproof                               | Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes – Type 1 _____ Type 2 _____                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis B vaccination   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears contact lenses                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> Wears medical information bracelet/necklace<br>For what purpose? _____ |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Wears dental appliance                                |   |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing problem                                       |   |  |

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_ Recent injuries: \_\_\_\_\_

Allergies: \_\_\_\_\_ Any information not covered above: \_\_\_\_\_

Medical conditions: \_\_\_\_\_

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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 Player: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

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