



## MEDICAL INFORMATION SHEET

| Name:  |          |   |               |          | Alternate emergency contac  | 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  Business Phone Number:()  Parent/Guardian #2: Name |          |   |               |          | Telephone: (  | Telephone: ()   |  |  |
|  |          |   |               |          | Date of last complete physica   | 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 |  |  |
| Business Phone Number:( )  |          |   |               |          | medical and that they also hav  |   |  |  |
| Please   | check t  | he appropriate response and provid                    | e details bel | ow if yo | u answer "Yes" to any of the questions.   |   |  |  |
| Yes □  | No □     | Medication  | Yes□          | No 🗆     | Asthma  | Yes $\square$ No $\square$ Health problem that would interfere with participation on a hockey team  |  |  |
| Yes □  | No □     | Allergies   | Yes □         | No □     | Trouble breathing during exercise   | Yes □ No □ Has had an illness that lasted more  |  |  |
| Yes □  | No □     | Previous history of concussions                       | Yes □         | No 🗆     | Heart Condition   | than a week and required medical attention in the past year   |  |  |
| Yes 🗆  | No 🗆     | Fainting or seizure during or after physical activity | Yes 🗆         | No 🗆     | Palpitations or Racing Heart  | Yes No Has had injuries requiring medical   |  |  |
| Yes□   | No □     | Near fainting or Brownouts                            | Yes □         | No 🗆     | Family history of heart disease   | 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  | Yes □ No □ Presently injured Injured body part:   |  |  |
| Yes 🗆  | No 🗆     | Wears contact lenses                                  | Yes 🗆         | No 🗆     | Diabetes – Type 1 Type 2  | Yes □ No □ 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  |  |  |
| Plea   | se give  | details if you answered "Yes" to any                  | of the abov   | e. (Use  | separate sheet if necessary)  |   |  |  |
| Medications:   |          |   |               |          | Recent injuries:  |   |  |  |
| Allergies:   |          |   |               |          | Any information not covere  | ed above:   |  |  |
| Med  | ical con | ditions:  |               |          |   |   |  |  |
| emerge<br>physici  | ncy and  | that no one can be contacted, team                    | nanagement    | will arr | ange to take my child to the hospital or a ph   | ion as soon as possible. In the event of a medical hysician if deemed necessary. I hereby authorize the horize release of information to appropriate people                                   |  |  |
| Date: Signature of Player:   |          |   | :             |          |   |   |  |  |
| Date: Signature of Parent or Guardian:                                       |          |   |               | or Guai  | rdian:  |   |  |  |
|  |          |   |               |          | ockey Canada will be held solely for the purpo<br>on and Electronic Documents Act as well as Ho | ses for which we collected it and in accordance with the ckey Canada's own Privacy Policy.  |  |  |