Hockey Canada

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 No Medication

Yes No Allergies

Yes No Previous history of concussions

Yes No Fainting or seizure during or after physical activity

Yes No Near fainting or Brownouts

Yes No Seizures and/or epilepsy 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 Palpitations or Racing Heart Yes

No Family history of heart disease

Yes No Family history of unexpected death during physical activity

Yes No Family history of unexplained death of a young person

Yes No Diabetes – Type 1____ Type 2_____

Yes No Wears medical information bracelet/necklace For what purpose? _____

Yes No Health problem that would interfere with participation on a hockey team

Yes No Has had an illness that lasted more than a week and required medical attention in the past year

Yes No Has had injuries requiring medical attention in the past year

Yes No Been admitted to hospital in the last year Yes No Surgery in the last year

Yes No Presently injured
Injured body part: _____

Yes No Vaccinations up to date
Date of last Tetanus Shot:_____ Yes No Hepatitis B vaccination

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: _____

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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