

MEDICAL INFORMATION SHEET

Name:					Alternate emergency conta	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): Parent/Guardian #1: Name Business Phone Number:() Parent/Guardian #2: Name					Dentist's Name:	Dentist's Name:		
					Telephone: (
					Date of last complete physic			
	,	Business Phone Number:(medical and that they also no	ave any medical	condition or injury problem checked by	
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 □		
Yes □	No □	Allergies	Yes □	No 🗆	Trouble breathing during exercise	Yes□ No□	participation on a hockey team Has had an illness that lasted more	
Yes □	No □	Previous history of concussions	Yes □	No 🗆	Heart Condition	163 🗆 110 🗆	than a week and required medical	
Yes 🗆	No 🗆	Fainting or seizure during or after physical activity	Yes □	No 🗆	Palpitations or Racing Heart	Yes□ No□	attention in the past year Has had injuries requiring medical	
Yes□	No □	Near fainting or Brownouts	Yes □	No □	Family history of heart disease	les 🗆 No 🗆	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		Presently injured ed body part:	
Yes 🗆	No 🗆	Wears contact lenses	Yes 🗆	No 🗆	Diabetes – Type 1 Type 2		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	
		details if you answered "Yes" to any						
Medications:					Recent injuries:	Recent injuries:		
Allergies:					Any information not cove	red above:		
Medical conditions:								
emerge physici	ncy and an and r	that no one can be contacted, team r	nanagement	will arr	dvised of any change in the above informa ange to take my child to the hospital or a p necessary treatment of my child. I also au	hysician if dee	med necessary. I hereby authorize the	
Date: Signature of Player:								
Date: Signature of Parent or Guardian:					dian:			
					ockey Canada will be held solely for the purp on and Electronic Documents Act as well as H			