

**PLAYER MEDICAL INFORMATION SHEET**  
FORM MUST BE COMPLETED FOR PLAYER TO GO ON THE ICE



Name: \_\_\_\_\_  
Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Business Telephone Numbers: Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
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 Epileptic                             |
| Yes No Fainting episodes during exercise   | Yes No Wears Glasses                         |
| Yes No Wears dental appliance  | Yes No Are lenses shatterproof?              |
| Yes No Heart Condition   | Yes No Wears Contact lenses                  |
| Yes No Hearing problem   | Yes No Asthma                                |
| Yes No Trouble breathing during exercise   | Yes No Allergies                             |
| Yes No Diabetic  | Yes No Medication                            |
| Yes No Wears a medic alert bracelet or necklace  | Yes No Surgery in the last year              |
| Yes No Has had an illness lasting more than a week in the past 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                     |
| Yes No Does your child have any health problem that would interfere with participation on a hockey team? |  |

**Please give details below if you answered YES to any of the above items.**

\_\_\_\_\_

Medications: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Medical Conditions: \_\_\_\_\_  
Recent Injuries: \_\_\_\_\_  
Last Tetanus Shot: \_\_\_\_\_  
Any Information not covered above: \_\_\_\_\_  
Date of Last complete physical examination: \_\_\_\_\_

Your physician should check any medical condition or injury problem 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/M.D. 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 Parent or Guardian: \_\_\_\_\_