



PLAYER MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____ Postal Code: _____

Telephone: _____ Provincial Health Number: _____

Mother's Name: _____ Father's Name: _____

Business Telephone Numbers: Mother: _____ Father: _____

Person to contact in case of an 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 | Fainting episodes during exercise |
| Yes | No | Epileptic |
| 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 | Diabetic |
| Yes | No | Has had an illness lasting more than a week in the past year |
| Yes | No | Medication |
| Yes | No | Allergies |
| Yes | No | Wears a medic alert bracelet or necklace |
| Yes | No | Does your child have any health problem that would interfere with participation on a hockey team? |
| Yes | No | Surgery in the last year. |
| Yes | No | Has been in hospital in the last year. |



BC HOCKEY
COACH COORDINATOR RESOURCE GUIDE

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

Please give details below if you answered 'Yes' to any of the above items.

Use a separate sheet if necessary.

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: _____