Medical Information & Waiver

Name: _____

DOB: Day_____ Month_____ Year_____

Address: _____

Postal Code: _____ Telephone: (_____) _____

Health Card Number _____

Emergency Contact Name: _____ Contact #: _____

Alternate Contact Name: _____ Contact#_____

Medical Information

Last physical examination: _____

Please circle the appropriate response and provide details below if you answer "Yes" to any of questions.

Yes No Do you have a previous history of concussions?

Yes No Do you have fainting episodes during exercise?

Yes No Are you epileptic?

Yes No Do you wears glasses or contact lenses?

Yes No Are your lenses shatterproof?

Yes No Do you wear a dental appliance?

Yes No Do you have hearing problems?

Yes No Do you suffer from asthma

Yes No Do you have trouble breathing during exercise _____

Yes No Do you have any heart conditions? _____

Yes No Are you diabetic? Type 1 ___ Type 2 ____

Yes No Do you have any allergies? _____

Yes No Do you carry an epi-pen? _____

Yes No Do you wear a medical info bracelet or necklace?
For what purpose? _____

Yes No Do you have any health problems that would interfere with participation on a hockey team? _____

Yes No Have you had any illness that lasted more than a week and required medical attention in the past year? _____

Yes No Have you had injuries requiring medical attention in the past year? _____

Yes No Have you been admitted to hospital in the last year? _____

Yes No Have you had surgery in the last year? _____

Yes No Are you presently injured? Injured body part: _____

Yes No Have you had your Hepatitis B vaccination?

Date of last Tetanus shot _____

Please list any medications/Prescription Drugs that you are currently taking

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I understand that it is my responsibility to keep the team Hockey Trainer 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, nursing and training staff to undertake examination, investigation and treatment of my child.

I also authorize the release of information to appropriate people (trainer, coach and physician) as deemed necessary.

Player Signature: _____ Date: _____

Parent Signature: _____ Date: _____