BRADFORD WEST GWILLIMBURY MINOR HOCKEY ASSOCIATION
P.O. Box 383, Bradford, Ontario L3Z 2A9

PLAYER MEDICAL INFORMATION SHEET

NAME: ____________________

DATE OF BIRTH: **DAY:** ________ **MONTH:** ________ **YEAR:** ________

ADDRESS: ____________________

POSTAL CODE: ____________ **TELEPHONE:** ____________

PROVINCIAL HEALTH #: ____________________

MOTHER'S NAME: ____________ **FATHER'S NAME:** ____________

WORK TELPHONE #: **MOTHER:** ____________ **FATHER:** ____________

Person to contract in case of accident or emergency, if parents are not available:

NAME: ____________ **TELEPHONE:** ____________

ADDRESS: ____________________

DOCTOR'S NAME: ____________ **TELEPHONE:** ____________

DENTIST 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 bracelets or necklace
yes	no	Does your child have any health problems 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
yes	no	Has had injuries required medical attention in the past year

Please give details below if you answered "yes" to any of the above items,

____

____

____

please use separate sheet if necessary.

MEDICATIONS: ____________________

ALLERGIES: ____________________

MEDICAL CONDITIONS: ____________________

RECENT INJURIES: ____________________

LAST TETANUS SHOT: ____________________

ANY INFORMATION NOT COVERED ABOVE: ____________________

DATE OF LAST PHYSICAL EXAMINATION: ____________________

Any medical condition or injury problem should be checked by your physician before participating in a hockey program.

I understand that this 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 herby 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 defined necessary.

SIGNATURE OF PARENT OR GUARDIAN: ____________________

DATE: ____________________