



MEDICAL INFORMATION SHEET

| Name: | _ Alternate emergency contact (if parents are not available) |
|--|---|
| Date of birth: Day Month Year | Name: |
| | Relationship to Player: |
| Address: | Telephone: () Cell: () |
| Postal Code: | Doctor's Name: |
| Telephone: () Cell: () | Telephone: () |
| Provincial Health Number (optional): | Dentist's Name: |
| Parent/Guardian #1: Name | Telephone: () |
| Business Phone Number:() | Date of last complete physical examination: |
| Parent/Guardian #2: Name | Before a player participates in a hockey program it is recommended that they have a — medical and that they also have any medical condition or injury problem checked by |
| Business Phone Number:() | |
| Please check the appropriate response and provide details below if you a | nswer "Yes" to any of the questions. |

Medication No 🗆 Asthma Yes 🗆 No 🗆 Health problem that would interfere with Yes 🗆 No 🗆 Yes 🗆 participation on a hockey team Allergies Trouble breathing during exercise Yes 🗆 No 🗆 Yes 🗆 No 🗆 Has had an illness that lasted more Yes 🗆 No 🗆 Yes 🗆 No 🗆 Previous history of concussions Yes 🗆 No 🗆 **Heart Condition** than a week and required medical attention in the past year Yes 🗆 No 🗆 Fainting or seizure during or after Yes 🗆 No 🗆 Palpitations or Racing Heart physical activity Has had injuries requiring medical Yes 🗆 No 🗆 Yes 🗆 No 🗆 Family history of heart disease attention in the past year Yes 🗆 No 🗆 Near fainting or Brownouts Family history of unexpected death Yes 🗆 No 🗆 Yes No Been admitted to hospital in the last year Yes 🗆 No 🗆 Seizures and/or epilepsy during physical activity Yes 🗆 No 🗆 Surgery in the last year Family history of unexplained death of Yes 🗆 No 🗆 Wears glasses Yes 🗆 No 🗆 a young person Yes I No I Presently injured No 🗆 Are lenses shatterproof Yes 🗆 Injured body part: _ Diabetes – Type 1____ Type 2_ Yes 🗆 No 🗆 Yes 🗆 No 🗆 Wears contact lenses Yes No Vaccinations up to date Wears medical information bracelet/necklace Yes 🗆 No 🗆 Date of last Tetanus Shot:_ Yes 🗆 No 🗆 Wears dental appliance For what purpose? _ Yes D No D Hepatitis B vaccination Yes 🗆 No 🗆 Hearing problem

I understand that it is my responsibility to keep the team Safety Person 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 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 Player: _____

Date:

Signature of Parent or Guardian: _

Disclaimer: Personal information used, disclosed, secured or retained by Hockey Canada will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as Hockey Canada's own Privacy Policy.