



PLAYER MEDICAL INFORMATION FORM

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE KEPT STRICTLY CONFIDENTIAL.

Player information:

Last Name:		First Name:		Date of Birth:	
Address:			City:		
Postal Code:			Telephone:		
Mother's Name:		Mother's Home Telephone:		Mother's Business Telephone:	
Father's Name:		Father's Home Telephone:		Father's Business Telephone:	
Doctor's Name:			Telephone:		
Dentist's Name:			Telephone:		

Emergency Contact, if parents not available:

Name:		Telephone:	
Address:		Relationship to Player:	

Player Personal Health History

Please check the appropriate response below pertaining to your child:

Condition	Yes	No
Previous History of concussions		
Fainting episodes during exercise		
Epileptic		
Wears glasses		
Are lenses shatterproof?		
Wears contact lenses		
Wears dental appliance		
Hearing problem		
Asthma		
Trouble breathing during exercise		
Heart condition		
Diabetic		
Had had an illness lasting more than a week in the past year		
Medication		
Allergies		
Wears a medic alert bracelet		
Does your child have any health problem that would interfere with participation on a hockey team?		
Surgery in the last year		
Has been in hospital in the last year		
Has had injuries requiring medical attention in the past year		
Presently injured		

Please give details if you answered "YES" to any of the above items. (Use separate sheet if necessary).

Medications:		Allergies:	
Medical Conditions:		Recent Injuries:	
Date of Last Tetanus Shot:		Last date of complete physical examination:	

Any Information not covered:

Any medical condition or injury problem should be checked by your physician 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 vent 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.

Signature of Parent or Guardian: _____

Date: _____

PLEASE NOTE THE BURLINGTON GIRLS HOCKEY CLUB **DOES NOT KEEP ANY INFORMATION ON FILE** RELATED TO THIS FORM. THIS FORM WILL BE DESTROYED/SHREDDED BY THE TRAINER AT THE END OF THE SEASON ALTERNATIVELY THE PARENT MAY REQUEST THIS FORM BE RETURNED.