

# Medical Information

Name	<input type="text"/>	Date of birth	<input type="text"/>
Address	<input type="text"/>	Phone #	<input type="text"/>
Mother's name	<input type="text"/>	Father's name	<input type="text"/>
Mother's contact #	<input type="text"/>	Father's contact #	<input type="text"/>
Alternate emergency contact	<input type="text"/>	Phone #	<input type="text"/>
Doctor	<input type="text"/>	Phone #	<input type="text"/>
		Dentist	<input type="text"/>
			Phone # <input type="text"/>

\* Before a player participates in a hockey program, any medical condition or injury should be checked by that individual's physician. Please check if applicable.

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|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Diabetic Type <input type="checkbox"/> 1 <input type="checkbox"/> 2               |
| <input type="checkbox"/> Concussions             | <input type="checkbox"/> Medication  |
| <input type="checkbox"/> Fainting episodes       | <input type="checkbox"/> Wears a medical information bracelet or necklace. Purpose <input type="text"/>    |
| <input type="checkbox"/> Epileptic               | <input type="checkbox"/> Any health problems that would interfere with participation in hockey             |
| <input type="checkbox"/> Wears glasses           | <input type="checkbox"/> Any illness lasting more than a week requiring medical attention in the past year |
| <input type="checkbox"/> Are lenses shatterproof | <input type="checkbox"/> Any injury requiring medical attention in the past year                           |
| <input type="checkbox"/> Wears contacts lenses   | <input type="checkbox"/> Has been admitted to the hospital in the past year                                |
| <input type="checkbox"/> Hearing problems        | <input type="checkbox"/> Surgery in the past year  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Presently injured   |
| <input type="checkbox"/> Trouble breathing       | <input type="checkbox"/> Vaccinations up to date. Date of last tetanus shot <input type="text"/>           |
| <input type="checkbox"/> Heart conditions        |  |

**Please give details if you checked any of the above. Use separate sheet if necessary.**

Medications

Any information not covered above

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 team Hockey Trainer to assess my child as 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 gaurdian \_\_\_\_\_ Date