HOCKEY MANITOBA

PLAYER MEDICAL INFORMATION SHEET

NAME:____

DATE OF BIRTH: DAY ________ MONTH ________ YEAR ________

ADDRESS:____

POSTAL CODE: ____________________________ TELEPHONE: ___________________________________

PROVINCIAL HEALTH NUMBER: ____

MOTHER'S NAME: ___________________________ FATHER'S NAME: ____________________________

BUSINESS TELEPHONE NUMBERS: MOTHER: ___________________ FATHER: ___________________

PERSON TO CONTACT IN CASE OF ACCIDENT OR EMERGENCY, IF PARENTS ARE NOT AVAILABLE.

NAME: ____ TELEPHONE: ______________________________

ADDRESS: ____

DOCTOR'S NAME: _____________________________ TELEPHONE: ______________________________

DENTIST'S 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 BRACELET OR NECKLACE

YES NO DOES YOUR CHILD HAVE NAY HEALTH PROBLEM 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 REQUIRING MEDICAL ATTENTION IN THE PAST YEAR

YES NO PRESENTLY INJURED

PLEASE GIVE DETAILS BELOW IF YOU ANSWERED “YES” TO ANY OF THE ABOVE ITEMS.

____
____
____
____
____

Use separate sheet if necessary.

MEDICATIONS: ____

ALLERGIES: ____

MEDICAL CONDITIONS: ____

RECENT INJURIES: ____

LAST TETANUS SHOT: ____

ANY INFORMATION NOT COVERED ABOVE: ____
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____

DATE OF LAST COMPLETE PHYSICAL EXAMINATION: _________________________________

* ANY MEDICAL CONDITION OR INJURY PROBLEM SHOULD BE CHECKED BY YOUR PHYSICIAN BEFORE PARTICIPATING IN A HOCKEY PROGRAM.

I UNDERSTAND THAT IS IT 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 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 PARENT OF GUARDIAN: ______________________________