OWHA MEDICAL FORM

MEDICAL INFORMATION SHEET

Name: ______________________________

Date of birth: Day __________ Month __________ Year ____________

Address: ______________________________

Postal Code: ____________________

Telephone: (____) ______________ Cell: (____) ______________

Provincial Health Number (optional): ______________________

Parent/Guardian #1: Name ______________________________

Business Phone Number:(____) ______________

Parent/Guardian #2: Name ______________________________

Business Phone Number:(____) ______________

Alternate emergency contact (if parents are not available)

Name: ______________________________

Relationship to Player: ______________________________

Telephone: (____) ______________ Cell: (____) ______________

Doctor's Name: ______________________________

Telephone: (______) ____________________

Dentist's Name: ______________________________

Telephone: (______) ____________________

Date of last complete physical examination: ______________________

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 their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes ☐ No ☐ Medication
Yes ☐ No ☐ Allergies
Yes ☐ No ☐ Previous history of concussions
Yes ☐ No ☐ Fainting or seizure during or after physical activity
Yes ☐ No ☐ Near fainting or Brownouts
Yes ☐ No ☐ Seizures and/or epilepsy
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 ☐ Palpitations or Racing Heart
Yes ☐ No ☐ Family history of heart disease
Yes ☐ No ☐ Family history of unexpected death during physical activity
Yes ☐ No ☐ Family history of unexplained death of a young person
Yes ☐ No ☐ Diabetes – Type 1____ Type 2______
Yes ☐ No ☐ Wears medical information bracelet/necklace For what purpose? ____________

Yes ☐ No ☐ Health problem that would interfere with participation on a hockey team
Yes ☐ No ☐ Has had an illness that lasted more than a week and required medical attention in the past year
Yes ☐ No ☐ Has had injuries requiring medical attention in the past year
Yes ☐ No ☐ Been admitted to hospital in the last year
Yes ☐ No ☐ Surgery in the last year
Yes ☐ No ☐ Presently injured
Injured body part: ________________
Yes ☐ No ☐ Vaccinations up to date
Date of last Tetanus Shot: ______________
Yes ☐ No ☐ Hepatitis B vaccination

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

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Medications: ______________________________

Allergies: ______________________________

Medical conditions: ______________________________

Recent injuries: ______________________________

Any information not covered above: ______________________________

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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: ______________________________

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