

NAKUSP & DISTRICT MINOR HOCKEY ASSOCIATION

P.O. Box 766

Nakusp, BC

VOG 1R0

PLAYER MEDICAL INFORMATION SHEET

Name _____ Date of Birth Day _____ Month _____ Year _____

Address _____ Postal Code _____

Home Telephone Number _____ Cell Phone Number _____

Provincial Health Number _____

Mother's Name _____ Fathers Name _____

Person to contact in case of accident or emergency, if parents are not available:

Name _____

Contact Numbers _____

Doctor's Name _____

Dentist's Name _____

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 Medication | Yes No Allergies |
| Yes No Surgery in the last year | Yes No Has been in hospital in the last year |
| Yes No Presently injured | |
| Yes No Has had an illness lasting more than a week in the past year | |
| Yes No Wears a medic alert bracelet or necklace | |
| Yes No Does your child have any health problem that would interfere with participation on a hockey team | |
| Yes No Has had injuries requiring medical attention in the past year | |

Please give details below if answered "Yes" to any of the above items (use separate sheet if necessary)

- 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 event no one can be contacted; team management will take my child to hospital/MD 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 or Guardian: _____