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: _____
_____
_____

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: _____

Submit