



Player Medical Information

First Name _____ Middle _____ Last _____
 Date of Birth _____ (Day/Month/Year)
 Address _____ Town _____ Postal Code _____
 Street: _____
 Mother's Name _____ Father's Name _____
 Mother's Phone _____ Father's Phone _____
 Mother's Work # _____ Father's Work # _____

Please provide a secondary contact for emergency in case the parents are not available.

Name: _____ Phone _____ Relationship _____
 Doctor: _____ Phone _____
 Dentist: _____ Phone _____

Yes	No	Condition	Yes	No	Condition
		Is there any previous history of concussions?			Has your child had any injuries requiring medical attention in the past year?
		Any history of fainting spells during exercise?			Any history of heart trouble?
		Any history of Epilepsy			Does your child have diabetes?
		Does your child have AIDS?			Has your child had any surgery or a prolonged hospital stay in the last year?
		Does your child wear any dental appliances?			Has your child had any prolonged illness in the past year (more than one week)
		Any history of asthma or respiratory illness or have they ever experienced trouble breathing during exercise?			Is your child on any medications?
		Does your child wear a medic alert bracelet or necklace?			Are there any known hearing problems?
		Does your child wear glasses or contact lenses? If yes, are they shatterproof?			Are there any known allergies? If yes, please list them below.
Allergies: _____					
I you answered yes to any of the previous questions, please give an explanation and list any medications that apply:					
Please list any information you think the coach will need pertaining to your child:					

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 that no one can be contacted, the team management has the authority to take my child to a hospital/medical facility if deemed necessary.
 I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.
 I also authorize the release of all information in this form to relevant medical personal, as well as information being supplied to the management team as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____