Player Medical Information Form

Division: _____ Date Completed: _____

Name: _____

Date of Birth: Day: ____ Month: ____ Year: _____

Address: _____

Postal Code: _____ Home Phone: _____ Cell Phone: _____

Provincial Health Number: _____

Mother's Name: _____ Business Phone: _____

Father's Name: _____ Business Phone: _____

Persons to contact in case of accident or emergency (if parents aren't available):

Name: _____ Phone: _____

Address: _____

Child's Doctor's Name: _____ Phone: _____

Child's Dentist's Name: _____ Phone: _____

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	Medications? If any? _____
Yes	No	Allergies? If yes, specify: _____