PLAYER MEDICAL INFORMATION FORM

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: ____