



HIGH PERFORMANCE PROGRAM

MEDICAL INFORMATION:

(Please complete all sections)

NAME: _____

ADDRESS: _____

POSTAL CODE: _____ PHONE: _____

HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

PROVINCAL MEDICAL CARD NUMBER: _____

PERSONS TO CONTACT IN CASE OF EMERGENCY AND PARENTS ARE NOT AVAILABLE:

EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____

DOCTOR: _____ PHONE: _____

DENTIST: _____ 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 | Medication |
| Yes | No | Allergies |
| Yes | No | Wears a Medic Alert Bracelet or Necklace |
| Yes | No | Any 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 provide details if you answered Yes to any of the above items.

Use separate sheet if necessary.

Medications: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Last Tetanus Shot: _____ Date of Last Physical: _____

Any information not covered above: _____

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 authorized release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Parent(s) or Guardian(s): _____