

Medical Information Sheet

Name:.....

Date of Birth: Day..... Month..... Year.....

Address:.....

Postal Code:..... Telephone: (.....)-.....

Mother's Name:..... Father's Name:

Business Phone Numbers: Mother:..... Father:.....

Alternate emergency contact (if parents are not available):

Name:..... Telephone:.....

Address:.....

Is there any information about the player's family structure that would be important for the staff to know (parents separated, divorced, custody issues, loss of family member, etc.)?

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Doctor: Telephone:.....

Dentist:..... Telephone:.....

Date of last complete physical examination:

***Before a player participates in a sports program, any medical condition of injury problem should be checked by that individual's family physician.**

Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

- | | | |
|-----|----|-----------------------------------|
| 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: Type 1.....Type 2..... |

- Yes No Medication
- Yes No Allergies: Will you be bringing an ANA Kit? EPI Pen?.....
- Yes No Wears a medical information bracelet or necklace.
For what purpose?
- Yes No Has any health problem that would interfere with participate on a Ringette team
- Yes No Has had an illness that lasted more than a week and required medical attention in the past year
- Yes No Has had injuries requiring medical attention in the past year
- Yes No Has been admitted to hospital in last year
- Yes No Surgery in the last year
- Yes No Presently injured: Injured body part:.....
- Yes No Vaccinations up to date Date of last Tetanus Shot.....
- Yes No Hepatitis B vaccination

Please give details if you answered “Yes” to any of the above. Use separate sheet if necessary.

Medications:

Allergies: Drugs, Food, Environmental Insect Stings or Bites, Other (please describe)

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Medical Conditions:

Recent injuries:.....

Any information not covered above:.....

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I understand that it is my responsibility to keep the team trainer advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician 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 of appropriate people (coach, physician) as deemed necessary.

Date:.....**Signature of Parent or Guardian:**.....

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