Please complete the Hockey Canada Medical Information Sheet online. After filling out the fields, save the document and email it to kimberleyminorhockey@hotmail.com.

HOCKEY CANADA

MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number (optional): _____

Parent/Guardian #1: Name _____

Business Phone Number:(____) _____

Parent/Guardian #2: Name _____

Business Phone Number:(____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Telephone: (_____) _____

Dentist's Name: _____

Telephone: (_____) _____

Date of last complete physical examination: _____
MM/DD/YY

Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

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

Yes ❑ No ❑ Medication
Yes ❑ No ❑ Allergies
Yes ❑ No ❑ Previous history of concussions
Yes ❑ No ❑ Fainting or seizure during or after physical activity
Yes ❑ No ❑ Near fainting or Brownouts
Yes ❑ No ❑ Seizures and/or epilepsy
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 ❑ Palpitations or Racing Heart
Yes ❑ No ❑ Family history of heart disease
Yes ❑ No ❑ Family history of unexpected death during physical activity
Yes ❑ No ❑ Family history of unexplained death of a young person
Yes ❑ No ❑ Diabetes – Type 1____ Type 2_____
Yes ❑ No ❑ Wears medical information bracelet/necklace
For what purpose? _____

Yes ❑ No ❑ Health problem that would interfere with participation on a hockey 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 ❑ Been admitted to hospital in the 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:_____
MM/DD/YY
Yes ❑ No ❑ Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. ***Use additional space at the bottom of the form if required or include more detail in email.***

_____

_____

_____

Medications:_____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

_____

I understand that it is my responsibility to keep the team Safety Person 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 to appropriate people (coach, physician) as deemed necessary.

Date: _____
MM/DD/YY

Signature of Player: _____
Type player's name in the field to sign

Date: _____
MM/DD/YY

Signature of Parent or Guardian: _____
Type name in the field to sign

Disclaimer: Personal information used, disclosed, secured or retained by Hockey Canada will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as Hockey Canada's own Privacy Policy.

Additional health details: