Medical information for the Hockey Season

Name: ____
DOB: day________ month_________ year_________
Address: ______________________________________
Postal Code: ___________________________________
Phone # ________________Cell # ________________
OHIP # ____
Parent/Guardian #1 name:_______________________
Phone # ________________ Cell # _______________
Parent/Guardian #2 name:_______________________
Phone # ________________ Cell # _______________

Alternate emergency contact (if parents not available)
Name: ____
Relationship to athlete: _________________________
Phone # ________________ Cell # _______________
Doctor's name: _________________________________
Phone # _______________________________________
Dentist name: __________________________________
Phone # _______________________________________
Date of last physical exam: _____________________
*Before a participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury checked by their family physician.

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

Yes__ No__ Medication
Yes__ No__ Allergies
Yes__ No__ History of Concussion
Yes__ No__ Fainting or seizure during or after physical activity.
Yes__ No__ Near fainting/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__ Wears hearing device

Yes__ No__ Asthma
Yes__ No__ Trouble breathing during exercise
Yes__ No__ Heart Condition
Yes__ No__ Palpitation 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___ / 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 last 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: _____________
Yes__ No__ Hepatitis B vaccination

Please provide details if you answered **'yes'** to any of the above.

I understand 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 apparent/guardian can not be contacted the team will arrange to have the athlete taken to the hospital if deemed necessary. I authorize the medical staff to provide necessary treatment. I authorize the release of information to the appropriate people (coach, physician) as deemed necessary.

Athlete (input name as signature): __________________________ Date: __________________________________

Parent/Guardian (input name as signature): ___________________________ Date: _________________________

*Personal information used, disclosed, secured, or retained will be held solely for the purposes for which we have collected it.

Revised August 2021