DARTMOUTH WHALERS MAJOR BANTAM HOCKEY CLUB

MEDICAL INFORMATION:
(Please complete all sections)

NAME: _____

ADDRESS: _____ POSTAL CODE: _____

PARENTS:_____ PHONE 1:_____PHONE 2:_____

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/physician 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 or Guardian: _____