Aberdeen Minor Hockey Association

Player Medical Information Sheet

Player Name: _____

Player Team Division: _____

Date of Birth: _____

Address:_____

Postal Code:_____

Cell: (____) ____ - _____

Provincial Health Number: _____

Parent/Guardian #1 Full Name:_____

Parent/Guardian #1 Number:_____

Parent/Guardian #2 Full Name:_____

Parent/Guardian #2 Number:_____

Doctor's Name & Office:_____

Doctor's Number: (_____) _____ - _____

Dentist's Name & Office: _____

Dentist's Number: (____) _____ - _____

Person to contact ***in case of accident or emergency*** if parents are not available:

Name:

Cell: (____) _____ - _____

Please check ***Yes*** to the appropriate response below pertaining to your child:

☐Previous history of concussions
☐Fainting episodes during exercise
☐Trouble breathing during exercise
☐Wears dental appliance
☐Wears glasses
☐Wears shatterproof lenses
☐Wears contact lenses
☐Hearing problem
☐Heart Condition
☐Asthma
☐Diabetic
☐Epileptic

☐Has had an illness lasting more than a week in the past year?
☐Wears a medic alert bracelet or necklace?
☐Has any health problem that would interfere with participation on hockey team?
☐Has had surgery in last year?
☐Has been in hospital in the last year?
☐Has had injuries requiring medical attention in the past year?
☐Presently injured?

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Please give details below if you answered ***Yes*** to any of the above items:

Allergies: _____

Current Medication(s):_____

Current Medical Condition(s):_____

Recent Injuries: _____

Last Tetanus Shot: _____

Any information not covered above:_____

Date of last complete physical examination:_____

*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 the hospital/physician/dentist listed if deemed necessary. I hereby authorize the hospital/physician/nursing staff/dentist to undertake examination investigation and necessary treatment of my child. I also authorize the release of information to appropriate people (coach, team management, physician) as deemed necessary.

Date: _____

Signature of Parent or Legal Guardian: _____