



MEDICAL INFORMATION SHEET

Name: _____ Circle One: PeeWee / Junior

Date of Birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Phone: (_____) _____

Mother's name: _____ Father's name: _____

OR Guardian's name: _____

Alternate emergency contacts if parents are not available:

Name: _____ Phone: (_____) _____

Relation: _____ Other Phone: (_____) _____

Name: _____ Phone: (_____) _____

Relation: _____ Other Phone: (_____) _____

Date of last complete physical examination: _____

*Before a player participates in the football program, any medical condition or injury should be checked by the athlete'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 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
- YES NO Wears a Medical Alert bracelet or necklace
For what purpose? _____
- YES NO Has a health problem that would interfere with playing football
- YES NO Had an illness that lasted longer 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 the past year
- YES NO Has had surgery in the past year
- YES NO Presently injured. Body part: _____
- YES NO Vaccinations are up to date
- YES NO Hepatitis B vaccination

Please give details if you answered "YES" to any of the above.

Use separate sheet if necessary.

Anything not covered above? _____

I understand that it is my responsibility to keep the team trainer(s) 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 by the team trainers.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.

I also authorize the release of information to appropriate people (coach, trainer, physician) as deemed necessary.

Date: _____ Signature of Parent/Guardian: _____

Travel Team Trainer: Adrienne Day

DISCLAIMER: Personal information used, disclosed, secured or retained will be held solely for the purpose for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.