Player Information Sheet
Registration/Medical

Please Print very clearly

Category (please circle one) Male U16,U15, U14 Female U18,U16,

Name/Nom _____ Date of Birth (dj/mm/ya) _____

Email address _____
*You must provide an email address as further information will be sent electronically

Mailing address _____

_____

_____

_____

Provincial Health Care Number _____

Telephone _____ Previous Year's Team _____

Current Team _____ Shot (please circle) L R

Position (please circle) G D F Forwards (please circle) C LW RW

Height _____ Weight _____ T-Shirt Size S M L XL

Mother's Name _____ Bus. Phone Number _____

Father's Name _____ Bus. Phone Number _____

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

Name _____ Telephone _____

Address _____

_____

_____

_____

Doctor's Name _____ Telephone _____

Dentist's Name _____ Telephone _____

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	Does your child have 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 give details below if you answered yes to any of the above items.

_____

_____

_____

_____

Medications _____

_____

Allergies _____

Last Tetanus Shot _____ Date of Last Physical _____

Any medical condition or injury 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/MD 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: _____ Parent 's Signature _____