North River Minor Hockey Association
Medical Form

Please complete all sections of form .

PLEASE PRINT

Name: ______________________________ **Date of Birth:** ______________________
Day Month Year

Mailing Address: ____

City:______________________**Prov:**________________**Postal Code:**______________

Telephone: _________________________ **Facsimile:** ________________________

Provincial Health Card Number: ____

Height: _____________ **Weight:** _______________

Manager's Name:____

Coach Name: ____

Coach Name: ____

Coach Name: ____

Trainer's Name:____

Mother's Name: __________________________ **Business Number:** _____________

Father's Name: __________________________ **Business 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:** ______________________

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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.

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Medications: ____

Allergies: ____

Medical Conditions: ____

Recent Injuries: ____

Last Tetanus Shot: __________________ **Date of Last Physical:** __________________

Any information not covered above: ____

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*** 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/MD 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:** ______________________________

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