



Windsor 'AAA' Zone

Player Information Form (Please Print)

Player's Name: _____

Date of Birth: Day: _____ Month: _____ Year: _____

Address: _____

Postal Code: _____

Health Card Number (optional): _____

Mother's Name: _____

Father's Name: _____

Home Phone: _____

Cell Phone: _____

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

Telephone: _____

Name: _____

Address: _____

Doctor's Name: _____

Dentist's Name: _____

Please circle the appropriate response below that pertains to your child:

| | | | | | |
|-----|----|---------------------------|-----|----|--|
| Yes | No | Allergies | Yes | No | Does/Has your child have/had injuries requiring medical attention in the past year |
| Yes | No | Asthma | Yes | No | Currently injured |
| Yes | No | Wear Glasses | Yes | No | An illness that lasted longer than one week in the past 12 months |
| Yes | No | Are lenses shatter-proof | Yes | No | Heart condition |
| Yes | No | Wear contact lenses | Yes | No | Wears Medic Alert bracelet/necklace |
| Yes | No | Diabetes | Yes | No | Receive counseling from an outside source |
| Yes | No | Epilepsy | Yes | No | Health problems that would interfere with participation in a full hockey program |
| Yes | No | Hearing problem | Yes | No | Surgery during the past 12 months |
| Yes | No | Take medication regularly | Yes | No | Been in hospital during the last 12 months |

Give details for each 'yes' answer – also provide any other relevant information.

Medication: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Any information not covered above: _____

Last Tetanus shot: _____

Date of last physical examination: _____

Any medical condition or injury should be checked by your physician before your child participates in a hockey program.

I/we 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 a hospital/MD if deemed necessary.

I/we understand that team management will authorize emergency medical treatment of my child in the event that I/we cannot be contacted.

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

I/we also authorize release of health information to appropriate people (coach/physician) as deemed necessary.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____