PLAYER MEDICAL FORM

Player Information

First Name | **Middle Name**

Last Name | **Medicare Number**

Home Address

Address (Line 2)

City

Province | **Postal Code**

Home Phone | **Cell Phone**

E-mail | **Date of Birth**

Emergency Contact

First Name | **Last Name**

Relationship

Home Phone | **Cell Phone**

Work Phone | **E-mail**

Secondary Emergency Contact

First Name | **Last Name**

Relationship

Home Phone | **Cell Phone**

Work Phone | **E-mail**

Medical Information

Doctor's Name | **Telephone #**

Dentist's Name _____ **Telephone #** _____

Previous history of concussions ☐ Yes ☐ No

Medication ☐ Yes ☐ No

Fainting espisodes during exercise ☐ Yes ☐ No

Allergies ☐ Yes ☐ No

Epileptic ☐ Yes ☐ No

Wears a medical information bracelet or necklace ☐ Yes ☐ No

Wears glasses ☐ Yes ☐ No

Has a health problem that would interfere with participation on a lacrosse team ☐ Yes ☐ No

Wears contact lenses ☐ Yes ☐ No

Has had an illness that lasted more than a week and required medical attention in the past year ☐ Yes ☐ No

Hearing difficulties ☐ Yes ☐ No

Had had injuries requiring medical attention in the past year ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Has been admitted to hospital in the last year ☐ Yes ☐ No

Trouble breathing during exercise ☐ Yes ☐ No

Surgery in the last year ☐ Yes ☐ No

Heart conditions ☐ Yes ☐ No

Presently Injured- *Body Part* _____

Vaccinations are up to date ☐ Yes ☐ No

Date of last tetanus _____

Diabetic ☐ No ☐ Type 1 ☐ Type 2

Hepatitis B vaccination ☐ Yes ☐ No

Please give details if you answered 'yes' to any of the above. Include any information not covered above. Use a separate sheet if necessary.

Parent(s) Information

Mothers Last Name | **Mothers First Name**

Home Phone # | **Cell #**

Fathers Last Name | **Fathers First Name**

Home Phone # : | **Cell #:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | **Relationship to player:**

Home phone # | **Cell #**

I understand that it is my responsibility to keep the team Coach and Trainer advised of any change in the above information as soon as possible. In the event of a medical emergency and no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary.

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 i.e. coach, trainer, physician as deemed necessary.

Parent/Guardian signature: | **Date:**

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