



WINDSOR MINOR HOCKEY ASSOCIATION

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