



# WINDSOR MINOR HOCKEY ASSOCIATION

Player Information Form  
*(Please Print)*

Player's Name: \_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Health Card Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address 1: \_\_\_\_\_

E-mail Address 2: \_\_\_\_\_

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 on rear of form.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_