MEDICAL INFORMATION SHEET

Name: ____

Date of birth: Day________________Month_______________Year

Address: ____

Postal Code: ____________________Telephone (________) ______________________________

Mother's Name___________________________________

Father's Name____________________________________

Business Telephone Numbers:

Mother____________________________Father___________________________

Alternate emergency contact (if parents are not available)

Name: ____Telephone: _____________________________

Address: ____

Doctor's Name: ___________________________________Telephone (_______) _____________________

Dentist's Name: _________________________________ Telephone (_______) _____________________

Date of last complete physical examination: _____________________________________

**Before a player participates in a lacrosse program, any medical condition or injury problem should be checked by that individual's family physician.

Please circle the appropriate response and provide details below if you answer "Yes: to any of the questions.

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	Hear Condition
Yes	No	Diabetic – Type 1________Type 2__________
Yes	No	Medication
Yes	No	Allergies
Yes	No	wears a medical information bracelet or necklace For What purpose? ______________________________
Yes	No	Has any health problem that would interfere with participation on a lacrosse team
Yes	No	Has had an illness that lasted more than a week and required medical attention in the past year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Has been admitted to hospital in the last year
Yes	No	Surgery in the last year
Yes	No	Presently injured. Injured boy part: ___________________
Yes	No	Vaccinations up to date Date of last Tetanus Shot: ___________________________
Yes	No	Hepatitis B Vaccination

Please give details if you answered "Yes" to any of the above. Use separate sheet if necessary
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Medications: ____

Allergies: ____

Medical conditions: ____

Recent injuries: ____

Any information not covered above: ____

I understand that it is my responsibility to keep the team Lacrosse Trainer advised of any change in the above information as soon as possible. In the event of a medical emergency and that 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 release of information to appropriate people (coach, physician) is deemed necessary.

Date: _______________Signature of Parent or Guardian: _____________________________________

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.