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## Player Medical Information Sheet

PLAYER INFORMATION					
Players Name:					
Birth date: (mm/dd/yyyy): / /		Health Card Number: (optional)			
Street address:			Home phone:		
City:		Prov:		Postal Code:	
MEDICAL QUESTIONNAIRE					
Date of Last Physical Examination:					
Before a player participates in a lacrosse program, any medical condition or injury should be checked by that individual's family doctor.					
Doctor's Name: (optional)				Telephone #:	
Dentist's Name: (optional)				Telephone #:	
Players vaccinations are up to date with Ontario's Routine Vaccination Schedule (circle one): YES NO					
Please check the appropriate response.					
If you answer "yes" to any of the following questions please provide details in the box provided on the next page.					
YES	NO		YES	NO	
		History of Concussions			Fainting Episodes During Physical Activity/Sport
		Allergies			Seizures and/or Epilepsy
		Diabetes			Heart Condition
		Requires Vision Correction			Wears Dental Appliance
		Asthma or Other Respiratory Condition			Hearing Difficulties
		Other health problem that may interfere with participation on a lacrosse team			Presently Injured
		In the last year has had any of the following: <ul style="list-style-type: none"> <li>- An illness that lasted more than a week and required medical attention.</li> <li>- Injuries requiring medical attention.</li> <li>- Admission to hospital</li> <li>- Surgery</li> </ul>			
		Wears medical information bracelet/necklace.			
		Requires prescribed medication (eg.. epipen or asthma inhaler) to be present during team activities.			
		I would like to prepare a Safety Plan to help ensure that my child's medical and/or other needs are supported during team activities.			



Parent/Guardian #1 Name:

Home Phone #:

( )

Cell Phone #:

( )

Parent/Guardian #2 Name:

Home Phone #:

( )

Cell Phone #:

( )

(additional contact in case parent/guardian cannot be reached)

Name of local friend or relative (not living at same address):

Relationship to player:

Cell phone #:

( )

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.

Date: \_\_\_\_\_

Signature of Player: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Guardian:\_\_\_\_\_

(Use separate sheet if necessary)

**DISCLAIMER:** Personal information used, disclosed, secured or retained by NKMLA Minor Lacrosse Association will be solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as the OLA and NKMLA Privacy Policy.