Port Coquitlam Minor Lacrosse

Medical Information Form

PLAYER INFORMATION

Player Name:		Date of Birth:
Home Address:		Postal Code:
Phone #:	Cell Phone #:	Email:
Doctor's Name:		Phone #:
Dentist's Name:		Phone #:
Care Card Number:		

EMERGENCY CONTACTS

Mother's Name:	Work #:	Cell phone #:
Father's Name:	Work #:	Cell phone #:
Alternate Contact:	Relationship to player:	
Home Phone:	Work #:	Cell phone #:

RELEVANT MEDICAL HISTORY: Please circle the appropriate responses and provide details below.

Y	N	Previous history of concussion	Y	N	Fainting episodes during exercise
Y	N	Epileptic	Y	N	Wears Glasses
Y	N	Wears Contact Lenses	Y	N	Are lenses shatterproof (glasses)
Y	N	Wears Dental Appliances	Y	N	Hearing Problem
Y	N	Asthma	Y	N	Trouble breathing during exercise
Y	N	Heart Condition	Y	N	Medication
Y	N	Diabetic: Type 1 ____ Type 2 ____	Y	N	Allergies
Y	N	Has any problems that would interfere with participation of a Lacrosse Team			
Y	N	Wears a medical information bracelet or necklace. For what purpose _____			
Y	N	Has had an illness that lasted more than a week and required medical attention in the past year			
Y	N	Has had any injuries requiring medical attention in the past year			
Y	N	Has been admitted to hospital in the last year			
Y	N	Surgery in the past year			
Y	N	Presently injured. Injured body part: _____			

Please give details if you answered "yes" to any of the above. Use separate sheet, as necessary.

I understand that it is my responsibility to keep the Team Manager 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 hereby authorize release of information to appropriate people (coach, physician, etc.) as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____