PARTICIPANT MEDICAL INFORMATION FORM

- CONFIDENTIAL -

Player's Name:

Parent(s) / Guardian(s) Name(s):

CONFIDENTIAL: Medical Information is confidential.
The above information will only be shared with the Technical Staff and Medical Professionals in the case of an emergency.

PLAYER INFORMATION

Player's Surname	First Name	Middle Name
Player's Contact Number	**Date of birth (day/month/year):**	**Sex (F/M)**

PARENT CONTACT INFORMATION

Mother's Surname	Mother's First Name	Home Number	Work & Cell./Pager No.
Father's Surname	Father's First Name	Home Number	Work & Cell./Pager No.

EMERGENCY CONTACT NUMBERS

1. Contact (Full Name)	Relationship to Player	Home Number	Work & Cell./Pager No.
2. Contact (Full Name)	Relationship to Player	Home Number	Work & Cell./Pager No.

MEDICAL INFORMATION & RELEVANT HISTORY

Ontario Health Insurance Plan (OHIP) No.	Family Physician
Doctor's Address	Contact Number

Does the participant have any allergies? *(please circle one)* YES NO

If yes, please specify. *(nuts, butter, needs epipen, etc)*

Have any permanent disabilities? *(please circle one)* YES NO

If yes, please specify what they are.

Is the participant taking any prescription drugs? *(penicillin, asthma inhalers, etc)* YES NO

If yes, please specify what medication has been prescribed and why you are taking it.

Does the participant…

wear eyeglasses?	Yes ☐	No ☐
wear braces on their teeth?	Yes ☐	No ☐
wear a soft or rigid brace?	Yes ☐	No ☐
wear a hearing aid?	Yes ☐	No ☐
wear contact lenses?	Yes ☐	No ☐
wear a medical alert bracelet?	Yes ☐	No ☐

If yes, please specify what is written on it _____

_____

Date of last tetanus immunization Blood Type

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Has the participant had or have any of the following?				
Arthritis or rheumatism	Yes	☐	No	☐
Asthma	Yes	☐	No	☐
Chronic nosebleeds	Yes	☐	No	☐
Concussion	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐
Diphtheria	Yes	☐	No	☐
Dislocated shoulder	Yes	☐	No	☐
Dizziness	Yes	☐	No	☐
Epilepsy	Yes	☐	No	☐
Fainting Headaches	Yes	☐	No	☐
Heart Trouble	Yes	☐	No	☐
Hernia	Yes	☐	No	☐
Skin Condition	Yes	☐	No	☐
Stomach problems	Yes	☐	No	☐
Swollen or painful joints	Yes	☐	No	☐
"Trick" or lock knee	Yes	☐	No	☐

Specify other injuries or illnesses *(sprains, broken bones, etc)*

What medications, if any, should the participant have on hand during the sport activity?

By whom should it be administered?

Participant's Signature *(if 18 years old or older)* date

Parent/Guardian's Signature date

Comments:

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