PARRY SOUND STINGERS MEDICAL INFORMATION SHEET

Player Name: _____

Date of birth: Day: _____ Month: _____ Year: _____

Address: _____ Postal Code: _____

Father's Name: _____ Cell #: _____ Home #: _____

Mother's Name: _____ Cell #: _____ Home #: _____

Athlete's cell # (*optional*): _____

Alternate emergency contact (if unable to reach parents/parents are not available)

Name: _____ Cell #: _____ Home #: _____

Relationship to Athlete: _____ Address: _____

Athlete's Doctor: _____ Tel #: _____

Athlete's Dentist: _____ Tel #: _____

Date of last complete physical examination: _____

Before participation in any sports program any medical condition, injury or problem should be assessed by a physician)

Medical Issue/Concern	**Circle one**		**Details (REQUIRED) if answer is yes**
Previous history of concussions	No	Yes	
Fainting episodes during exercise	No	Yes	
Seizures	No	Yes	
Asthma	No	Yes	
Breathing difficulties during exercise	No	Yes	
Heart condition	No	Yes	
Diabetes – IDDM NIDDM	No	Yes	
Wears glasses/contacts	No	Yes	
Are glasses shatterproof	No	Yes	
Wears dental appliance	No	Yes	
Wears medical information bracelet or necklace	No	Yes	
Has any other health problems that might impact participation on team	No	Yes	
Has had an injury or illness that has lasted more than one week and/or required medical attention within last year	No	Yes	
Has been admitted to hospital within last year	No	Yes	
Surgery in past year	No	Yes	
Presently injured?	No	Yes	Injured area Treatment plan?

PARRY SOUND STINGERS MEDICAL INFORMATION SHEET

Current medications: _____

_____

_____

Allergies (*include degree of allergy and any treatment plans in place for athlete*):

_____

_____

_____

I certify that my child is up to date with their vaccinations (required) _____ Parent Initials

I understand that it is my responsibility to keep the Parry Sound Stingers Basketball Trainer and/or Coach advised of any changes in the above information and/or medical conditions as soon as possible. In the event of a medical emergency and that no one listed above can be contacted, I understand and accept that the team management will arrange to take my child (athlete) to a hospital or seek treatment from a physician if deemed necessary.

I hereby authorize the physician(s) and/or allied health staff to undertake examinations, investigations and necessary treatment of my child.

I also authorize release of information to my child's coach and/or trainer as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____

Printed name of Parent or Guardian: _____

***Disclaimer*: Personal information collected, used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the Personal Health Information and Protection Act (PHIPA), (2004).**