SMLA

PLAYER MEDICAL INFORMATION SHEET

Player's Name_____

Address_____

City / Province:_____Postal Code:_____

Telephone: _____

Date of Birth: Day: _____Month:_____ Year:_____

Provincial Health # _____

Mother's Name:_____ Home Phone: _____

Cell Phone: _____

Father's Name:_____ Home Phone: _____

Cell Phone: _____

Person to contact in case of accident or emergency, if parents are not available:

Name:_____ Phone:_____

Address: _____

Doctor's Name:_____Phone:_____

Dentist's Name:_____Phone:_____

Please check the appropriate response below pertaining to your child:

YES	NO		YES	NO	
		Previous history of concussions			Wears contact lenses
		Fainting episodes during exercise			Wears dental appliance
		Medication			Hearing problem
		Diabetic			Asthma
		Epileptic			Has had an illness lasting more than a week in the past year
		Wears glasses			Has had injuries requiring medical attention in the past year
		Are lenses shatterproof?			Surgery in the last year
		Allergies			Wears a medic alert bracelet or necklace
		Trouble breathing during exercise			Has been in hospital in last year
		Heart condition			Presently injured
		Has a health problem that would interfere with participation on a Lacrosse team			

MEDICAL INFORMATION SHEET CONTINUED

SMLA

Player's Name:_____

Please give details below if you answered "Yes" to any of the previous items. Use separate sheet if necessary.

_____

_____

_____

_____

Medications:_____

Allergies:_____

Medical Conditions:_____

Recent Injuries:_____

Last Tetanus Shot:_____

Date of last complete physical exam:_____

Any information not covered above:_____

Any medical condition or injury problem should be checked by your physician before participating in a lacrosse program._____

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take my child to hospital/M.D. 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) as deemed necessary.

Date:_____Signature of Parent of Guardian: _____