



BRAMPTON MINOR LACROSSE PLAYER MEDICAL INFORMATION

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (__) _____ Cell: (__) _____

Provincial Health Number (optional): _____

Parent/Guardian #1: Name _____

Business Phone Number: (__) _____

Parent/Guardian #2: Name _____

Business Phone Number: (__) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (__) _____ Cell: (__) _____

Doctor's Name: _____

Telephone: (_____) _____

Dentist's Name: _____

Telephone: (_____) _____

Date of last complete physical examination: _____

Before a player participates in a lacrosse program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes No Medication

Yes No Allergies

Yes No Previous history of concussions

Yes No Fainting or seizure during or after physical activity

Yes No Near fainting or Brownouts

Yes No Seizures and/or epilepsy

Yes No Wears glasses

Yes No Are lenses shatterproof

Yes No Wears contact lenses

Yes No Wears dental appliance

Yes No Hearing problem

Yes No Asthma

Yes No Trouble breathing during exercise

Yes No Heart Condition

Yes No Palpitations or Racing Heart

Yes No Family history of heart disease

Yes No Family history of unexpected death during physical activity

Yes No Family history of unexplained death of a young person

Yes No Diabetes - Type 1 __ Type 2 ____

Yes No Wears medical information bracelet/necklace For what purpose? _____

Yes No Health problem that would interfere with participation on a lacrosse team

Yes No Has had an illness that lasted more than a week and required medical attention in the past year

Yes No Has had injuries requiring medical attention in the past year

Yes No Been admitted to hospital in the last year

Yes No Surgery in the last year

Yes No Presently injured Injured body part: _____

Yes No Vaccinations up to date Date of last Tetanus Shot: _____

Yes No Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

Medications: _____

Recent injuries: _____

Allergies: _____

Any information not covered above: _____

Medical conditions: _____

I understand that it is my responsibility to keep the team Safety Person 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 also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____

Signature of Player: _____

Date: _____

Signature of Parent or Guardian: _____

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