



Name _____

Birth Date: Day _____ Month _____ Year _____

Address _____

Postal Code: _____ Telephone: _____

O.H.I.P. Initial & No. _____

Mother's Name: _____ Father's Name: _____

Business Telephone Numbers: Mother's _____ Father's _____

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

Telephone: _____ Name: _____

Address: _____

Doctor's Name: _____

Dentist's Name: _____

Please circle the appropriate response below pertaining to your child.

Yes	No	Allergies	Yes	No	Has had an illness lasting more than a week in the past year
Yes	No	Asthma			
Yes	No	Wears glasses	Yes	No	Heart condition
Yes	No	Are lenses shatter-proof	Yes	No	Wears a medic alert bracelet or necklace
Yes	No	Wears contact lenses	Yes	No	Receiving counselling from an outside source
Yes	No	Diabetic	Yes	No	Does your child have any health problem that would interfere with his/her participating in a full hockey program
Yes	No	Epileptic			
Yes	No	Hearing problem			
Yes	No	Medication being taken regularly at home	Yes	No	Has had a surgical operation in the past year
Yes	No	Has had injuries requiring medical attention in the past year	Yes	No	Has been in hospital (except tonsillectomy) in the past year

Please give details below if you answered "Yes" to any of the above items.

PLEASE ENTER ANY INFORMATION NOT COVERED ABOVE. _____

Date of your child's last complete medical examination: _____

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 admit my child to the hospital if deemed necessary.

I hereby authorize the physician and nursing staff of any Emergency Unit to undertake examination, investigation and necessary treatment of my child.

_____ Date

_____ Signature of Parent or Guardian

