COWICHAN CAPITALS JR 'A' HOCKEY CLUB

PLAYER INFORMATION SHEET

2019 SPRING PREP TEAM

MEDICAL FORM

PLEASE DO NOT WRITE IN THIS SPACE: **JERSEY: COLOUR:** ____________________ **No:** __________

COMPLETED FORM MUST BE RECEIVED PRIOR TO START OF TRYOUT

PLAYER

NAME ____________________________________ **AGE:** _______ **BIRTH DATE M**________ **D** _____ **Y**________

B.C. MEDICAL HEALTH INSURANCE: YES ☐ NO ☐ CARD NUMBER: -______________________

OTHER PROVINCIAL INSURANCE and/or ADDITIONAL FAMILY INSURANCE: YES ☐ NO ☐

PROVINCE and / or NAME OF INSURANCE COMPANY: ____________________________________

POLICY #: ____

YOUR ADDRESS: ____________________________________ **TELEPHONE: [H]** (_____)_________- ___________

____________________________________ **[C]** (_____)_________- ___________

____

POSTAL / ZIP CODE _______________ **E / Mail:** ________________________________

IF YOU ARE A U.S. PLAYER, YOU MUST HAVE PRIMARY HEALTH INSURANCE COVERAGE. PLEASE ENSURE YOU HAVE A COPY OF YOUR COVERAGE WITH YOU AT ALL TIMES DURING THE CAMP.

NAME OF INSURER:____POLICY No. ____________________

EXPIRY DATE: Month: ________________ Day: ________ Year: ______________

PARENTS

MOTHER _______________________ **TELEPHONE: [H] SAME AS ABOVE ☐ OR (**_______**)**________**-** ___________

[C] (________**)**__________**-** _______________

[W] (________**)**__________**-** _______________

FATHER _______________________ **TELEPHONE: [H] SAME AS ABOVE ☐ OR (**_______**)**________**-** ___________

[C] (________**)**__________**-** _______________

[W] (____**)**___**)**__________**-** _______________

EMERGENCY CONTACTS

FAMILY PHYSICIAN ____________________________________ **TELEPHONE [W] (**_____**)**________**-** ___________

PERSON TO CONTACT IN ACCIDENT OR EMERGENCY, *IF PARENTS CANNOT BE CONTACTED*

NAME ______________________________________ **TELEPHONE [H] (**_____**)**________**-** ___________

RELATIONSHIP ______________________________ **[C] (**_____**)**________**-** ___________

[PLEASE COMPLETE REVERSE SIDE OF FORM]

(CONFIDENTIAL WHEN COMPLETED)

PLAYER MEDICAL INFORMATION

A) HEIGHT:FT.____IN. WEIGHT:_____LBS.

B) Date of last complete Physical examination. ____________

C) Date of Last TETANUS BOOSTER (Check one): Less than 3 yrs ☐: 3 - 5 yrs ☐: More than 5 yrs ☐

D) Please check the appropriate responses:

	YES	NO		YES	NO	N/A
Allergies to Medication	☐	☐	Wears glasses	☐	☐	
Allergies - other	☐	☐	Are lenses shatter proof	☐	☐	☐
Asthma	☐	☐	Wears contact lenses	☐	☐	
Diabetic	☐	☐	Hearing Problem	☐	☐	
Epileptic	☐		Medic Alert bracelet / necklace	☐	☐	
Heart Condition	☐	☐	Dental bridges, plates or braces	☐	☐	

	YES	NO
Medication or other supplements [vitamins etc.] being regularly taken at home	☐	☐
Has had an illness lasting more than a week in the past year	☐	☐
Has had injuries requiring medical attention in the past year [outpatient basis]	☐	☐
Has been hospitalized in the past year	☐	☐
Has had a surgical operation in the past year	☐	☐
Has had one or more concussions in the past 2 years	☐	☐
Has had injuries to his head, back or joints in the past 2 years	☐	☐
Other health issues that may interfere with participation in a full hockey program	☐	☐
Are you presently recovering from an injury	☐	☐

PLEASE PROVIDE ADDITIONAL INFORMATION TO ANY OF THE ABOVE RESPONSES CHECKED AS "YES"

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D) PLEASE ENTER ANY ADDITIONAL INFORMATION NOT COVERED ABOVE WHICH MAY AFFECT YOUR ABILITY TO PLAY A FULL HOCKEY PROGRAM

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E) I understand that it is my responsibility to immediately advise the Camp Tryout Training staff of any change in the above information. In the event no one can be contacted, the Camp training staff or management will admit the player to the hospital if deemed necessary.

Authorization is hereby provided to the training staff as well as the physicians and nursing staff of any Hospital or Emergency Unit to undertake necessary examination, investigation and necessary treatment of the player.

____________________ ____________________________

DATE PARENT OR GUARDIAN SIGNATURE

COMPLETED FORM MUST BE RECEIVED PRIOR TO START OF CAMP