STRATHROY MINOR LACROSSE ASSOCIATION

MEDICAL FORM

(Please Print)

Today's date:			
PLAYER INFORMATION			
Last Name:	First:	Middle:	
Birth date: (mm/dd/yyyy) / /		Age:	Sex: ❑ M ❑ F
Street address:		Home phone no. ( ) :	
City:	Prov:	Postal Code:	
Health Card Number:			
Date of Last Physical Examination: *Before a player participates in a lacrosse program, any medical condition or injury should be checked by that individual's family doctor.*			
Doctor's Name:		Telephone #:	
Dentist's Name:		Telephone #:	

Please circle the appropriate response and provide details below if you answer 'YES' to any of the questions:

YES	NO	CONDITION	YES	NO	CONDITION
		Previous history of concussions			Medication
		Fainting episodes during excercise			Allergies
		Epileptic			Wears a medical information bracelet or necklace
		Wears glasses			Has any health problem that would interfere with participation on a lacrosse team
		Wears contact lenses			Has had an illness that lasted more than a week and required medical attention in the past year
		Hearing difficulties			Had had injuries requiring medical attention in the past year
		Asthma			Has been admitted to hospital in the last year
		Trouble breathing during exercise			Surgery in the last year
		Heart conditions			Presently Injured - Body Part:
		Vaccinations are up to date Date of last tetanus:			Hepatitis B vaccination
		Diabetic Type 1:	Type 2:		

Please give details if you answered 'yes' to any of the above. Include any information not covered above. Use the back of this sheet if necessary.

PARENT (S) INFORMATION	
Mother's Last Name:	First:
Home Phone #: ( )	Cell Phone #: ( )
Father's Last Name:	First:
Home Phone #: ( )	Cell Phone #: ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to player:	Home phone #: ( )	Cell phone #: ( )

I understand that it is my responsibility to keep the team Coach and Trainer advised of any change in the above information as soon as possible. In the event of a medical emergency and 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 the release of information to appropriate people i.e. coach, trainer, physician as deemed necessary.

Patient/Guardian signature *Date*

DISCLAIMER: Personal information used, disclosed, secured or retained by Strathroy Minor Lacrosse Association will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.

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