GLOUCESTER MINOR LACROSSE MEDICAL INFORMATION FORM

Player's name: _____ Date of birth: ____/____/____
dd mm yr

Home address: _____ Postal code: _____

Phone #: _____ Cell phone #: _____

E-mail: _____

Emergency Contacts

Mother' Name: _____ Work #: _____ Cell: _____

Father's Name: _____ Work #: _____ Cell: _____

Alternate contact: _____ Relationship to player: _____

Phone: Home: _____ Work: _____ Cell: _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Health Card number: _____

Relevant Medical History: Please circle the appropriate response and provide details below.

Yes	No	Previous history of concussions	Yes	No	Fainting episodes during exercise
Yes	No	Epileptic	Yes	No	Wears Glasses
Yes	No	Wears Contact lenses	Yes	No	Are lenses shatterproof (glasses)
Yes	No	Wears Dental Appliance	Yes	No	Hearing Problem
Yes	No	Asthma	Yes	No	Trouble breathing during exercise
Yes	No	Heart Condition	Yes	No	Medication
Yes	No	Diabetic- Type 1____ Type 2 _____	Yes	No	Allergies

Yes No Has any problem that would interfere with participation of a Lacrosse Team
Yes No Wears a medical information bracelet or necklace. For what purpose _____
Yes No Has had an illness that lasted more than a week and required medical attention in the past year.
Yes No Has had any injuries requiring medical attention in the past year
Yes No Has been admitted to hospital in the last year
Yes No Surgery in the last year
Yes No Presently injured. Injured body part _____

Please give details if you answered "Yes" to any of the above. If you have sustained a Concussion, please list, when, in which sport, the degree and the recovery time. Use separate sheet if necessary.

_____
_____
_____

I understand that it is my responsibility to keep the Team Manager 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 hereby authorize release of information to appropriate people (coach, physician, etc.) as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____

Medical information is confidential. This information will be kept with the Team at all times and will be available to authorized individuals only.