



Port Moody Minor Lacrosse

Player Medical Form

Name _____ Parent Name _____

Birthdate: mm/dd/yy _____ Phone Home _____

Care Card # _____ Cell _____

Emergency Contact _____ Work _____

(If Parents are not available) Parent Name _____

Name _____ Home _____

Phone _____ Cell _____

Doctor _____ Work _____

Phone _____

Dentist _____

Phone _____

I understand that it is my responsibility to keep the team management informed of any changes in the following information, and that in the event no one can be contacted, team management will take my child to a doctor or hospital if deemed necessary. I hereby authorize the doctor and nursing staff to undertake the examination, investigation and necessary treatment of my child _____

(Player name)

SIGNATURE OF PARENT OR GUARDIAN

DATE

MEDICAL HISTORY

Circle The Appropriate Response Pertaining To Your Child

YES NO HISTORY OF CONCUSSIONS

YES NO ALLERGIES:MEDICAL ALERT BRACELET YES NO

YES NO FAINTING EPISODES DURING EXERCISE

YES NO EPILEPTIC

YES NO WEARS GLASSES OR CONTACTS:SHATTERPROOF LENSES YES NO

YES NO ASTHMA OR DIFFICULTY BREATHING DURING EXERCISE

YES NO HEARING PROBLEMS : HEARING AIDS YES NO

YES NO HEART CONDITION

YES NO DIABETIC

YES NO TAKING ANY MEDICATION

YES NO SURGERY WITHIN THE PAST YEAR

YES NO HOSPITALIZATION WITHIN THE PAST YEAR

YES NO INJURY REQUIRING MEDICAL ATTENTION WITHIN THE PAST YEAR

Please Give Details If you Answered Yes To Any Of The Above
