

Mitchell Astros
MEDICAL INFORMATION SHEET



Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: (____) _____ Cell: (____) _____

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

Business Telephone Numbers: Mother _____ Father _____

Alternate emergency contact (if parents are not available)

Name: _____ Telephone: _____

Relationship to player: _____

Doctor's Name: _____ Telephone: (____) _____

Dentist's Name: _____ Telephone: (____) _____

Date of last complete physical examination: _____

* Before a player participates in a baseball program, any medical condition or injury problem should be checked by that individual's family physician.

Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes No Medication

Yes No Allergies

Yes No Previous history of concussions

Yes No Fainting episodes during exercise

Yes No Seizures and/or Epilepsy

Yes No Wears glasses

Yes No Are lenses shatterproof

Yes No Wears contact lenses

Yes No Wears dental appliance

Yes No Hearing problem

Yes No Asthma

Yes No Trouble breathing during exercise

Yes No Heart Condition

Yes No Family History of Heart Disease

Yes No Diabetes Type 1 _____ Type 2 _____

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 health problems that would interfere with participating on a baseball team
Yes No Has had 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: _____
Yes No Vaccinations up to date
Date of last Tetanus Shot: _____
Yes No Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. Use separate sheet if necessary

Medications: _____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

I understand that it is my responsibility to keep the team Hockey Trainer 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 also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Player: _____

Date: _____ Signature of Parent or Guardian: _____

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.