Baseball NS / HPBA MEDICAL INFORMATION SHEET

Player Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: (____) _____

Provincial Health Number (**optional**): _____

Parent 1's Name: _____ Parent 2's Name: _____

Business Telephone Numbers: Parent 1 _____ Parent 2 _____

Alternate emergency contact (if parents are not available)

Name: _____ Telephone: _____

Address: _____

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

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

Date of last complete physical examination: _____

** Before a player participates in a sports 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.

		Previous history of concussions
		Fainting episodes during exercise
		Epileptic
		Wears glasses
		Are lenses shatterproof
		Wears contact lenses
		Wears dental appliance
		Hearing problem
		Asthma
		Trouble breathing during exercise
		Heart Condition
		Diabetic – Type 1_____ Type 2_____
		Medication

		Allergies
		Wears a medical information bracelet or necklace For what purpose? _____
		Has any health problem that would interfere with participation on a baseball team
		Has had an illness that lasted more than a week and required medical attention in the pastYear
		Has had injuries requiring medical attention in the past year
		Has been admitted to hospital in the last year
		Surgery in the last year
		Presently injured. Injured body part: _____
		Vaccinations up to date
		*Date off last Tetanus Shot:*_____
		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 Safety Person 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 Parent or Guardian: _____**

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