

LAKE COWICHAN DISTRICT MINOR BASEBALL ASSOCIATION

PLAYER MEDICAL & EMERGENCY INFORMATION

DIVISION: _____ YEAR (at start of season): _____

PLAYER FIRST NAME:		PLAYER LAST NAME:		
DATE OF BIRTH:	<u>MONTH</u>	<u>DAY</u>	<u>YEAR</u>	GRADE in school:
HOME ADDRESS:		MAILING ADDRESS:		
* 1st PARENT/GUARDIAN NAME:		• 2nd PARENT/GUARDIAN NAME:		
* PRIMARY CONTACT PHONE NUMBER: CELL / HOME		• PRIMARY CONTACT PHONE NUMBER: CELL / HOME		
* SECONDARY CONTACT PHONE NUMBER: CELL / HOME		• SECONDARY CONTACT PHONE NUMBER: CELL / HOME		
* RELATIONSHIP TO PLAYER:		• RELATIONSHIP TO PLAYER:		

**** EMERGENCY CONTACT ** (other than parent/guardian)**

<u>NAME:</u>	<u>CONTACT #:</u>
<u>RELATIONSHIP TO PLAYER:</u>	<u>CONTACT #:</u>

<u>DOCTOR NAME:</u>	<u>DOCTOR PHONE #:</u>
<u>DENTIST NAME:</u>	<u>DENTIST PHONE #:</u>

Date of last complete physical exam (if known) :	
DATE of last <u>TETANUS</u> vaccination:	DATE of last <u>HEPATITIS B</u> vaccination:
PERSONAL HEALTH NUMBER:	

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

medication	YES	NO	seizures	YES	NO
previous history of concussions	YES	NO	asthma	YES	NO
fainting during exercise	YES	NO	allergies / EpiPen	YES	NO
wears dental appliance	YES	NO	wears glasses	YES	NO
hearing impairment	YES	NO	are lenses shatterproof?	YES	NO
trouble breathing during exercise	YES	NO	wears contact lenses	YES	NO
heart condition	YES	NO	diabetes	YES	NO

wears a medical information bracelet or necklace **YES** **NO**

has any health problem that would interfere with participation on a sports team **YES** **NO**

has had an illness that lasted more than a week and required medical attention in the past 12 months **YES** **NO**

has had injuries requiring medical attention in the past 12 months **YES** **NO**

has had SURGERY or been ADMITTED to hospital in the past 12 months **YES** **NO**

presently injured (please specify) **YES** **NO**

Please provide details if you answered YES to any of the above, OR if you would like to provide additional information. Use a separate piece of paper if necessary.

- **I understand** that it is my responsibility to keep team SAFETY personnel advised of any change to the above information as soon as possible. **I understand** that in the event of a medical emergency and that none of the above listed individuals can be contacted, team management/coaches will arrange to take my child to the hospital or a physician if deemed necessary.
- **I authorize** the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.
- **I authorize** release of information to appropriate personnel (coach / physician) as deemed necessary.

Signature of parent/guardian:	DATE:
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