



**Woodstock Wildcats**  
**Medical Information Sheet**

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Player's Name: \_\_\_\_\_

Date of Birth (dd/mm/yyyy): \_\_\_\_\_ Division: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mother's / Guardian's Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Father's / Guardian's Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Person to contact in case of accident or emergency, if parents not available.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please circle the appropriate response below pertaining to your child.

- |     |    |                                   |
|-----|----|-----------------------------------|
| Yes | No | Previous history of concussions   |
| Yes | No | Fainting episodes during exercise |
| Yes | No | Epileptic                         |
| 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                   |

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WWGHA,  
PO Box 20089, 3 Huron Street  
Woodstock, Ontario  
N4S 8X8

[www.woodstockwildcats.com](http://www.woodstockwildcats.com)



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- Yes No Diabetic  
Yes No Has had an illness lasting more than a week in the past year  
Yes No Medication  
Yes No Allergies  
Yes No Wears a medic alert bracelet or necklace  
Yes No Surgery in the past year  
Yes No Has been in the hospital in the last year  
Yes No Has had injuries requiring medical attention in the past year  
Yes No Presently injured  
Yes No Does your child have any health problem that could interfere with participation on a hockey team.

Please give details below if you answered "Yes" to any of the above items. (Use separate sheet if needed).

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical conditions\*: \_\_\_\_\_

Recent Injuries\*: \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Information not covered above: \_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_

\*Any medical condition or injury problem should be checked by your physician before any participation in a hockey program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take my child to the hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake the examination, investigation and any necessary treatment of my child.

I also authorize the release of information to appropriate people (coach, trainer and physician) as deemed necessary.

Signature of Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_