



## Wildcat Volleyball Club

### PLAYER MEDICAL INFORMATION SHEET

Name: \_\_\_\_\_  
Date of birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Provincial Health Number: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Business Telephone Numbers: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Person to contact in case of accident or emergency, if parents are not available.  
Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_  
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  
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 Does your child have any health problem that would interfere with participation on this volleyball team?  
Yes No Surgery in the last year.  
Yes No Has been in hospital in the last year.  
Yes No Has had injuries requiring medical attention in the past year.  
Yes No Presently injured.

Continued over>>

Please give details below if you answered "Yes" to any of the above items.

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Use separate sheet if necessary

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

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

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

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

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

Any information not covered above: \_\_\_\_\_

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

\* Any medical condition or injury problem should be checked by your physician before participating in a volleyball 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 hospital/M.D. 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: \_\_\_\_\_