

SALMON ARM MINOR HOCKEY PLAYER HOCKEY INFORMATION

PERSONAL INFORMATION:

Name of player: _____ Sex: M _____ F _____

Address: _____ Postal Code: _____

Home telephone #: _____ Mutual Aid # _____

Mother's/Guardian's name: _____ Res# _____ Bus# _____

Father's/Guardian's name: _____ Res# _____ Bus# _____

HEALTH INFORMATION

Medical #: _____

Doctor's Name: _____ Telephone # _____

Dentist's Name: _____ Telephone #: _____

Does your child have any medical condition or physical limitation that we should be aware of?

Such as: Severe allergies, diabetes, Asthma, epilepsy, heart conditions,
eye glasses, contact lenses, hearing condition, etc. YES _____ No _____

Does your child receive any special counselling that we should be aware of? YES _____ No _____

Does your child take any long-term medication? YES _____ No _____

In the last year has your child:
1. Had an illness lasting more than week? YES _____ No _____

2. Had injuries requiring medical attention? YES _____ No _____

3. Had any surgical operations? YES _____ No _____

Please give details if you answered "Yes" to any of the above questions and list any other information, which may be helpful to us.

I understand that it is my responsibility to keep the Association advised of any change in the above information as soon as possible and that in the event no one can be contacted, minor hockey personnel will admit my child to the hospital if deemed necessary.

Date: _____ Signature of Parent or Guardian: _____