



Kitchener Dutchmen Jr. B Hockey Club  
**MEDICAL INFORMATION**  
2008-2009

**PLAYERS INFORMATION:**

First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_  
Health Card #: \_\_\_\_\_

**PARENTS INFORMATION:**

Address: \_\_\_\_\_  
\_\_\_\_\_

Mothers Name: \_\_\_\_\_

Phone: Home: (    ) \_\_\_\_\_ - \_\_\_\_\_

Work: (    ) \_\_\_\_\_ - \_\_\_\_\_

Fathers Name: \_\_\_\_\_

Phone: Home: (    ) \_\_\_\_\_ - \_\_\_\_\_

Work: (    ) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT:**

Please record the person to contact in case of accident or emergency, if your parents are not available

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

Address: \_\_\_\_\_  
\_\_\_\_\_

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

Doctor: \_\_\_\_\_

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

Dentist: \_\_\_\_\_

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

- Yes  No - Previous History of Concussions?
- Yes  No - Epileptic?
- Yes  No - Wears Glasses?
- Yes  No - Contact Lenses?
- Yes  No - Wears Dental Appliances?
- Yes  No - Asthma?
- Yes  No - Trouble Breathing When Exercise?
- Yes  No - Heart Condition?
- Yes  No - Medic Alert Bracelet or Necklace?
- Yes  No - Any health problems that would interfere with playing on a hockey team?

- Yes  No - Fainting Episodes during exercise?
- Yes  No - Medication?
- Yes  No - Shatterproof Lenses?
- Yes  No - Allergies?
- Yes  No - Hearing Problem?
- Yes  No - Diabetic?
- Yes  No - Surgery in the last year?
- Yes  No - Presently Injured?
- Yes  No - In the Hospital in the last year?

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

Medical Conditions: \_\_\_\_\_

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

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

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

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

Date of last physical exam: \_\_\_\_\_

*Note: Any medical condition or injury problem should be checked by your physician prior to participating in our 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 examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician etc.) as deemed necessary.

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

**THE KITCHENER DUTCHMEN JUNIOR B HOCKEY CLUB**

154 Forfar Ave : Kitchener, ON N2B 3A1 : Tel: (519) 859-1300 : Fax: (519) 571-0132 : [info@kitchenerdutchmen.com](mailto:info@kitchenerdutchmen.com)