This form will be kept with your son or daughter's respective coach. Please contact the Athletic Director and coach if there are any changes in your son or daughter's medical information throughout the season of play. It is recommended that you consult with your family physician to determine whether or not your child is fit to participate in contact sports.

|  |  |
| --- | --- |
| Name: Grade: | Date of Birth (DD-MMM-YY): |
| Current Address: | City: |
| Postal Code: | Current Home Phone Number: |
| Mother's Name: | Father's Name: |
| Mother's Contact Number (after 3pm): | Father's Contact Number (after 3pm): |
| Student's BC Care Card Number: | |

Person to contact in case of an emergency, if player's parents are not available:

# Name: Tel:

# Doctor's Name: Tel:

Dentist Name: Tel:

**Critical Medical Information for Coach:**

|  |
| --- |
| Is your child currently taking medication, including asthma medications? (please list) |
| Does your child have any allergies? (medications, foods, pollen, etc.) (please list) |
| Last tetanus shot (date): |

# **Medical Conditions:**

|  |
| --- |
|  |

# **Recent Injuries:**

|  |
| --- |
|  |

**Any information not covered above:**

|  |
| --- |
|  |

Please circle Yes or No for the following questions:

* Has your child ever passed out during exercise? Y / N
* Has your child ever been dizzy during exercise? Y / N
* Has your child had trouble breathing during exercise? Y / N
* Has your child ever had chest pains? Y / N
* Has your child ever had high blood pressure? Y / N
* Has your child ever been told he or she has a heart murmur? Y / N
* Does your child have a heart condition? Y / N
* Has your child ever had a head injury/ concussion? Y / N
* Has your child ever lost consciousness? Y / N
* Has your child ever had a seizure? Y / N
* Has your child ever had a stinger, burner or pinched nerve? Y / N
* Has your child ever had heat cramps? Y / N
* Does your child use special pads or braces? Y / N
* Is your child epileptic? Y / N
* Does your child wear glasses? Y / N
* Does your child wear contact lenses? Y / N
* Does your child wear a dental appliance? Y / N
* Does your child have a hearing problem? Y / N
* Does your child have asthma? Y / N
* Is your child diabetic? Y / N
* Does your child have blood born pathogens – Hep C, HIV, etc. Y / N
* Does your child wear a medic alert bracelet or necklace? Y / N
* Does your child have any health problems that would interfere with participation on a school team? Y / N
* Has your child had surgery in the last year? Y / N
* Has your child been in the hospital in the last year? Y / N
* Has your child had injuries requiring medical attention in the past year? Y / N

Please explain and “Yes” answers here and any other concerns applicable (use the back of the form if necessary).

Any medical condition or injury should be checked by your Doctor before continued participation a school sport.

I understand that it is my responsibility to keep the Athletic director and the coach advised of any change the above information as soon as possible.

In the event that no one can be contacted when there is a medical emergency the coaches will take my child to the hospital/doctor if deemed necessary.

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

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

**By signing below, you are confirming that you have read the Concussion Guidelines document found on Parent Connect**.

Parent Signature Date:

**By signing below, you are confirming that your child is considered physically fit to participate in sport**.

Parent Signature Date: