Semiahmoo Minor Lacrosse Player Medical Information Sheet

Player's Name	e:				
Date of Birth:		Day	Month	Year	
Address:					
Postal Code:			Telephone:		
Care Card Nu	mber:				
Mother's Nam	e:		Father's Nam	ne:	
Business or C	ell Num	bers:	Mother:	Father:	
Doctor's Name	e:		Telephone:	Telephone:	
Dentist's Name:			Telephone:	Telephone:	
Person to co	ntact in	case of accid	lent or emergency if	parents are available:	
Name:			Telephone:		
Relationship to	o Child:				
Address:					
Please circle the appropriate response below pertaining to your child:					
Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No No No No No	Wears a medical alert bracelet or necklace Previous history of concussions Epileptic Wears eyeglasses Wears contact lenses Wears dental appliance Hearing problem Asthma Trouble breathing during exertion Heart Condition Diabetes Has had a serious illness/surgery in the past year Medication Allergies Has a health problem that may interfere with Participation in Lacrosse			

If you answered "Yes" to any of the above items, please provide information & details:

Please note, while safe and controlled, Lacrosse is a vigorous, physical game. Any medical condition or injury problem should be checked by a physician before participating in a Lacrosse program.

I understand that it is my responsibility to keep the team advised of any change in the above information as soon as possible.

I consent to having my child taken to the nearest hospital/M.D. in the event of a medical emergency. I hereby authorize the physician and medical staff to undertake examination, investigation and necessary treatment of my child.

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

Signature of Parent/Legal Guardian:

Date: