COWICHAN CAPITALS JR 'A' HOCKEY CLUB

PLAYER INFORMATION SHEET

2017 SPRING CAMP

PLEASE DO NOT WRITE IN THIS SPACE: **JERSEY: COLOUR:** _____ **No:** _____

COMPLETED FORM MUST BE RECEIVED PRIOR TO START OF CAMP

PLAYER

NAME _____ **AGE:** _____ **BIRTH DATE M**_____**D** _____ **Y**_____

B.C. MEDICAL HEALTH INSURANCE: **YES** ☐ **NO** ☐ **CARD NUMBER:** -_____

OTHER PROVINCIAL INSURANCE and/or ADDITIONAL FAMILY INSURANCE: **YES** ☐ **NO** ☐

PROVINCE and / or NAME OF INSURANCE COMPANY: _____

POLICY #: _____

YOUR ADDRESS: _____ **TELEPHONE: [H]** (_____)_____-_____

_____ **[C]** (_____)_____-_____

_____

POSTAL / ZIP CODE _____ **E / Mail:** _____

IF YOU ARE A U.S. PLAYER, YOU MUST HAVE PRIMARY HEALTH INSURANCE COVERAGE. PLEASE ENSURE YOU HAVE A COPY OF YOUR COVERAGE WITH YOU AT ALL TIMES DURING THE CAMP.

NAME OF INSURER :_____POLICY No. _____

EXPIRY DATE : Month : _____ Day : _____ Year : _____

PARENTS

MOTHER _____ **TELEPHONE: [H] SAME AS ABOVE** ☐ **OR** (_____)_____-_____

[C] (_____)_____-_____

[W] (_____)_____-_____

FATHER _____ **TELEPHONE: [H] SAME AS ABOVE** ☐ **OR** (_____)_____-_____

[C] (_____)_____-_____

[W] (____)___)_____-_____

EMERGENCY CONTACTS

FAMILY PHYSICIAN _____ **TELEPHONE [W]** (_____)_____-_____

PERSON TO CONTACT IN ACCIDENT OR EMERGENCY, *IF PARENTS CANNOT BE CONTACTED*

NAME _____ **TELEPHONE [H]** (_____)_____-_____

RELATIONSHIP _____ **[C]** (_____)_____-_____

[PLEASE COMPLETE REVERSE SIDE OF FORM]

(CONFIDENTIAL WHEN COMPLETED)

PLAYER MEDICAL INFORMATION

A) HEIGHT:FT.____IN. WEIGHT:_____LBS.

B) Date of last complete Physical examination. _____

C) Date of Last TETANUS BOOSTER (Check one): Less than 3 yrs ☐: 3 - 5 yrs ☐: More than 5 yrs ☐

D) Please check the appropriate responses:

	YES	NO		YES	NO	N/A
Allergies to Medication	☐	☐	Wears glasses	☐	☐	
Allergies - other	☐	☐	Are lenses shatter proof	☐	☐	☐
Asthma	☐	☐	Wears contact lenses	☐	☐	
Diabetic	☐	☐	Hearing Problem	☐	☐	
Epileptic	☐		Medic Alert bracelet / necklace	☐	☐	
Heart Condition	☐	☐	Dental bridges, plates or braces	☐	☐	
Medication or other supplements [vitamins etc.] being regularly taken at home				☐	☐	
Has had an illness lasting more than a week in the past year				☐	☐	
Has had injuries requiring medical attention in the past year [outpatient basis]				☐	☐	
Has been hospitalized in the past year				☐	☐	
Has had a surgical operation in the past year				☐	☐	
Has had one or more concussions in the past 2 years				☐	☐	
Has had injuries to his head, back or joints in the past 2 years				☐	☐	
Other health issues that may interfere with participation in a full hockey program				☐	☐	
Are you presently recovering from an injury				☐	☐	

PLEASE PROVIDE ADDITIONAL INFORMATION TO ANY OF THE ABOVE RESPONSES CHECKED AS "YES"

_____

_____

_____

D) PLEASE ENTER ANY ADDITIONAL INFORMATION NOT COVERED ABOVE WHICH MAY AFFECT YOUR ABILITY TO PLAY A FULL HOCKEY PROGRAM

_____

_____

_____

E) I understand that it is my responsibility to immediately advise the Camp Training staff of any change in the above information. In the event no one can be contacted, the Camp training staff or management will admit the player to the hospital if deemed necessary.

Authorization is hereby provided to the training staff as well as the physicians and nursing staff of any Hospital or Emergency Unit to undertake necessary examination, investigation and necessary treatment of the player.

_____ _____

DATE PLAYER'S SIGNATURE

_____ _____

DATE PARENT OR GUARDIAN SIGNATURE
[REQUIRED IF PLAYER IS UNDER 18 YEARS]

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