



BLOMHA Player Health Sheet

PLEASE PRINT

Name	Birth Date	D	M	Y
Address	Email			
Postal Code	Telephone	Cell		
Mother's Name	Father's Name			
Business Telephone	Mother	Father		

Contact person in case of accident or emergency if parents are not available:

Name	Telephone
Address	
Doctor's Name	Telephone
Dentist's Name	Telephone

PLEASE CIRCLE THE APPROPRIATE RESPONSE BELOW PERTAINING TO YOUR CHILD

1. Asthma			Yes	No
2. Wears glasses	Yes	No	If yes, are they shatter-proof glasses	
3. Allergies			Yes	No
4. Diabetic			Yes	No
5. Epileptic			Yes	No
6. Hearing problem			Yes	No
7. Medication being taken at home			Yes	No
8. Has had injuries requiring medical attention in the past year			Yes	No
9. Has had an illness lasting more than one week			Yes	No
10. Heart condition			Yes	No
11. Wears a medical alert bracelet or necklet			Yes	No
12. Receiving counseling from an outside source			Yes	No
13. Has any health problem that would interfere with the expected level of participation			Yes	No
14. Has been in the hospital except for a tonsillectomy in the past year			Yes	No
15. Is there a history of concussions?			Yes	No
16. If Yes, how many?		When?		

Please give details below if 'Yes' answered to any of the above:

I understand it is my responsibility to keep the team management advised on any changes in the above information as soon as possible and in the event no one can be contacted, team management staff will admit my child to the hospital if deemed necessary. I hereby authorize the physician and nursing staff of any 'emergency unit' to undertake examination, investigation, and necessary treatment of my child.

Date	Signature of Parent or Guardian
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All information will be kept in strict confidence by team staff.