Saint John District Youth Hockey Association

Player Registration/ Medical Information

Name:_____ **Team:**_____

DOB: Day: _____ **Month:**_____ **Year:**_____ **Position:** _____

Address:_____ **City:**_____

Province:_____ **Postal Code:**_____ **Phone#:**_____

Mother/ Guardian:_____ **Contact#:**_____

Father/ Guardian:_____ **Contact #:**_____

E-Mail (1):_____

E-Mail (2)_____

Emergency Contact Information if Parent/ Guardian Unavailable.

Name (1):_____ **Phone#:**_____

Name (2):_____ **Phone#:**_____

Doctor:_____ **Phone#:**_____

Dentist:_____ **Phone#:**_____

Medical Information:

Medicare #:_____ **Last Tetanus Shot:**_____

Allergies:_____

Medications:_____

Recent Injuries:_____ **Last Complete Physical:**_____

Is your child currently enrolled in Minor Hockey Yes No

Please Complete Back Page

Please circle the appropriate response below pertaining to the player

Previous history of concussions	Yes	No
Fainting episodes during exercise	Yes	No
Epileptic	Yes	No
Wears Glasses	Yes	No
Wears Contact Lenses	Yes	No
Wears Dental Appliance	Yes	No
Hearing Problem	Yes	No
Asthma	Yes	No
Heart Condition	Yes	No
Diabetic	Yes	No
Wears a Medic Alert Bracelet or Necklace	Yes	No
Surgery in the Last Year	Yes	No
Has had injuries requiring medical attention in past year	Yes	No

Please give details below if you answered "YES" to any of the above questions.

***Any medical condition or injury should be checked by your physician before participating in a hockey program.**

I understand that it is my responsibility to keep team management advised of any change in the above information as soon as possible in the event that something arises and team management has to transport my child to hospital/ MD if deemed necessary.

Signature Parent/ Guardian:_____ Date:_____