Surrey Eagles Jr. A Hockey Club
2199 148th Street
Surrey, BC, Canada, V4A 8L5
Phone: (604)531-4625
Phone: (604)535-6710
www.surreyeagles.ca

Medical Information Sheet
Please complete this form and submit to Damon Pugerude (damon@surreyeagles.ca)

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Your Cell Number (_____) _____

Provincial Health Number: _____ Province: _____

Mother's Name: _____ Father's Name: _____

Cell Phone Numbers: Mother's: (_____) _____ Father's: (_____) _____

Work Phone Number: Mother's: (_____) _____ Father's: (_____) _____

Alternate Emergency Contact:

Name: _____ Telephone (_____) _____

Address: _____

Doctor's Name: _____ Telephone (_____) _____

Dentist's Name: _____ Telephone (_____) _____

Date of last complete physical examination: _____

*Before a player participates in a hockey program, any medical condition or injury problem should be checked by that individual's family physician.

Please circle the appropriate response and provide details below if you answer "**Yes**" to any of the questions.

Yes ◯ **No** ◯ 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** ◯ Trouble breathing during exercise
Yes ◯ **No** ◯ Heart Condition
Yes ◯ **No** ◯ Diabetic – Type 1 _____ Type 2 _____

Yes ◯ **No** ◯ Medication
Yes ◯ **No** ◯ Allergies
Yes ◯ **No** ◯ Wears a medical information bracelet or necklace
Yes ◯ **No** ◯ Was ill in the past year that lasted more than a week and required medical attention
Yes ◯ **No** ◯ Has had injuries requiring medical attention in the past year
Yes ◯ **No** ◯ Has been admitted to a hospital in the past year
Yes ◯ **No** ◯ Surgery in the past year
Yes ◯ **No** ◯ Presently injured. Injured body part: _____
Yes ◯ **No** ◯ Vaccination up to date. Date of last Tetanus Shot: _____
Yes ◯ **No** ◯ Hepatitis B vaccination
Yes ◯ **No** ◯ Family history of mental illness
Yes ◯ **No** ◯ History of Depression
Yes ◯ **No** ◯ Has Had COVID-19.
Yes ◯ **No** ◯ Vaccinated for COVID-19. Date of Shots:_____

Please give details if you answered "**Yes**" to any of the above. Use a separate sheet if necessary

_____

_____

_____

Medications: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Any Information not covered above: _____

I understand that it is my responsibility to keep the team Athletic Trainer and Coaching Staff advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take me to the hospital or a physician if deemed necessary. I hearby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____
(Under the Age of 18)