



# PENTICTON VEES JR 'A' HOCKEY CLUB PLAYER INFORMATION SHEET

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 \_\_\_\_\_ 19 \_\_\_\_\_

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 NOS: \_\_\_\_\_

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 CAN NOT BE CONTACTED**

NAME \_\_\_\_\_ TELEPHONE [H] ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ [C] ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

# PLAYER MEDICAL INFORMATION

A) HEIGHT: \_\_\_\_\_ FT. \_\_\_\_\_ IN.                      WEIGHT: \_\_\_\_\_ LBS.

B) Date of last complete Physical examination. \_\_\_\_\_

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

C) Please check the appropriate responses:

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

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

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

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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 he 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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