



BURNABY DEVILS PLAYER MEDICAL INFORMATION

TEAM: _____

COACH: _____

Surname: _____

Given Name: _____

Date of Birth: M ____ D ____ Y ____

Age: ____

Parents/Guardians: _____

Address: _____

Home Tel #: _____ **Mom Cell #:** _____ **Dad Cell #:** _____

Contact in case of accident: _____ **Home Tel #:** _____

Relationship to child: _____ **Cell #:** _____

Health Card # _____

Family Doctor: _____ **Tel #** _____

ANY KNOWN ALLERGIES: _____

Please specify if your child has any medical condition(s) that may affect his/her participation during the season (e.g. epilepsy, diabetes, asthmas, orthopedics, etc.).

Does your child take any regular medications at home? If yes, please detail type, dosage, days & times.

Date of Last Tetanus Booster: M ____ D ____ Y ____

I understand that it is my responsibility to keep the team management advised of any changes in the above information as soon as possible, and that in the event no one can be contacted, team management will admit _____ to the hospital if deemed necessary.

I hereby authorize the physicians and staff of any Emergency Department to undertake examination, investigation and necessary treatment.

Parent/Guardian Signature: _____ **Date:** _____

**This document will be presented to the attending emergency medical staff
whenever the player requires such attention.**