



Year	_____
Team	_____

IN CASE OF EMERGENCY (Part 1 of 2)

PLAYER NAME: _____

DATE OF BIRTH: _____
(Year / Month / Day)

PLAYER BOOK NUMBER _____

PARENT NAME(S) _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

CELL PHONE _____

ALTERNATE CONTACT (IN THE EVENT YOU CANNOT BE CONTACTED) _____

HOME PHONE _____ BUSINESS PHONE _____

ONTARIO HEALTH CARD # _____

EXTENDED HEALTH INSURANCE CO. _____

POLICY # _____ CERTIFICATE _____

FAMILY DOCTOR _____ PHONE _____

DENTIST _____ PHONE _____

EMERGENCY MEDICATION WHICH MY CHILD WILL CARRY AT ALL TIMES: _____

I HAVE LISTED DETAILED MEDICAL/PERSONAL INFORMATION ON THE SPECIAL CONCERNS/ NEEDS FORM IN THIS PACKAGE (PAGE 2). YES NO

THE COACH, ASSISTANT COACHES, OR TEAM MANAGER MAY TAKE MY CHILD FOR EMERGENCY SERVICES AT A LOCAL HOSPITAL SHOULD THE NEED ARISE. I UNDERSTAND THAT I WILL BE CONTACTED AS SOON AS POSSIBLE SHOULD THIS SITUATION OCCUR. YES NO

I UNDERSTAND THAT THE PERSONAL AND HEALTH INFORMATION I AM PROVIDING WILL BE USED FOR EMERGENCY PURPOSES ONLY AND I AGREE TO THE RELEASE OF THIS INFORMATION AS REQUIRED IN AN EMERGENCY. I ALSO UNDERSTAND THAT THE TEAM MANAGER WILL KEEP THE INFORMATION SECURE FOR THE DURATION OF THE SEASON. AT THE END OF THE SEASON THIS INFORMATION WILL BE EITHER RETURNED TO ME OR SHREDDED. YES NO

(Continued: Part 2 on following page.)



IN CASE OF EMERGENCY (Part 2 of 2)

Year _____
Team _____

PLAYER NAME _____

PARENT NAME(S) _____

SPECIAL NEEDS/CONCERNS & HISTORY of HEAD INJURY/CONCUSSIONS

If you have any special needs or concerns of a personal nature regarding your child please identify them for us in the space below. If applicable, include detailed information regarding EpiPen and medication. If you would rather speak to the Coach or Team Manager, please indicate here whom you have or will be speaking to about it.

It is your responsibility to make us aware of any changes or additions to special concerns detailed above.

PARENT SIGNATURE(S): _____ **DATE** _____