

PLAYER PROFILE & EMERGENCY CONTACT FORM



PLAYER EMERGENCY CONSIDERATION

If a player is injured and needs immediate medical attention, it will be useful in certain circumstances if knowledge and information is available to health care professionals and coaching staff regarding player health insurance, pre-existing medical conditions, emergent contacts, etc.

This information is to be provided voluntarily, will be used in cases of emergency only, and is collected and will be treating in accordance with the NUSC Privacy Policy.

To be completed by Player (if 18 or over) or Parent/Guardian (if under 18).

PLAYER PROFILE AND EMERGENCY INFORMATION

PERSONAL INFO			
Player's Name:		Date of Birth:	
		Day:	Month: Year:
Street Address:		Province:	
City:	Apt:	Postal Code:	
Player OHIP #:		Sex: M or F	
Supplemental Health Insurance Company:		Policy/Group/Plan #:	
Mother's Name:	Primary Tel #:	Emergent #:	Email:
Father's Name:	Primary Tel #:	Emergent #:	Email:
Guardian's Name:	Primary Tel #:	Emergent #:	Email:
EMERGENCY CONTACT INFO			
Emergency Contact Name:	Emergent # (1):	Emergent # (2):	Relationship to Player:
Physician's Name:		Tel #:	City:

PLAYER MEDICAL HISTORY

Allergies:

- None
- Unknown
- Known Medical Allergies:

Cardiac:

- None
- Unknown
- Angina
- Arrhythmia
- Cardiomyopathy
- Congenital
- Other:

Surgery:

- None
- Unknown
- Abdominal
- Heart
- Lung
- Neurological
- Other:

Chronic Illnesses:

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Dialysis / Renal | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> TB |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV + | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> CVA / TIA | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Paralysis | _____ |

Current Medications:

- None
- Unknown
- Other: _____

ADDITIONAL INFORMATION

Please note anything you wish coaching staff or medical personnel to be aware of:

SIGNATURE

This information is true to the best of my knowledge. I understand that this information must be updated should medical or personal information change.

Name:	Signature:	Date:
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