

## PLAYER MEDICAL RECORD

**To be completed by all players participating in competitions, training, camps, or other ice hockey events. If a player is under 18, a Parent / Guardian must complete the form.**

### PERSONAL DETAILS:

Name:		Date of Birth: / /
Club/Team:		League:
Ambulance Subscriber:	YES / NO	Medicare No:
Private Health Fund:	YES / NO	Name of Health Fund:

**MEDICAL INSURANCE:** Please note that in the event of injury, any Insurance policy for players is voided if the player was not wearing IHQ approved equipment. It is recommended that players investigate what the national insurance policy covers and consider taking out their own private policies if they are unduly concerned about the possibility of injury.

### MEDICAL CONDITIONS:

Please indicate any known medical conditions(s) relevant to the above named player. Where you circle "YES" please describe the nature of the problem, or attach a letter from your doctor.

Heart Problems	YES	NO	
Blood Pressure	YES	NO	
Asthma	YES	NO	<b>If YES, asthma medication must be brought to each session for self administration if needed.</b>
Epilepsy	YES	NO	
Allergies	YES	NO	
Drug Reactions	YES	NO	
Operations	YES	NO	
Dietary	YES	NO	
Other (please specify)	YES	NO	
I wear contact lenses or spectacles:	YES	NO	
I have dental (orthodontic) work done:	YES	NO	
I have attached documents to this form:	YES	NO	

### MEDICAL PRACTITIONER:

Name of Family Doctor or Medical Centre	
Address:	Telephone:

I hereby authorize the Manager/Coach/Medic to obtain any medical or associated assistance, which they deem to be necessary, should any medical condition or accident occur. I agree to pay any ambulance, medical, dental, and/or pharmaceutical expenses incurred on my/my child's behalf which are not covered by my personnel/family ambulance subscription, medical benefits (or travel insurance in the case of overseas travel) I further authorize qualified practitioners to perform surgery, administer anesthetic and/or administer blood transfusions if such and eventuality should arise. I understand that, should such circumstance arise, the Manager/Coach/Medic will endeavor to contact my next of kin/me by telephone in the first instance.

Name of Player or Parent/Guardian	Signature	Date
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### DISCLAIMER:

I hereby authorise the medical practitioners identified above to provide to hospital authorities or other qualified medical practitioners(s) additional information concerning any of the medical conditions identified on this form should such need arise.

Name of Player or Parent/Guardian	Signature	Date
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