

# MEDICAL INFORMATION FORM

Please fill out completely. Information is mandatory for participation.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

D. O. B. \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Telephone (H) # \_\_\_\_\_ (W) # \_\_\_\_\_

Cell/ Dad # \_\_\_\_\_ Cell/Mom # \_\_\_\_\_

## General Health History (Circle all that apply. Provide details below.)

Any recent injury, illness or infectious disease? Y/N

Ever been diagnosed with a heart murmur? Y/N

Have any chronic or recurring illness? Y/N

Have you ever had an eating disorder? Y/N

Ever been hospitalized? Y/N

Ever had back or joint problems (e.g. knees)? Y/N

Ever had surgery? Y/N

Do you use an orthopedic appliance? Y/N

Have frequent headaches? Y/N

Do you have skin problems? Y/N

Ever had a head injury or been knocked unconscious? Y/N

Have you had mononucleosis in past 12 months? Y/N

Do you have frequent ear infections? Y/N

Do you have any sleep-related problems (e.g. Sleepwalking)? Y/N

Do you wear glasses or contacts? Y/N

Have you ever passed out during/after exercise? Y/N

Ever had seizures or high blood pressure? Y/N

Ever had chest pains during/after exercise? Y/N

Ever sought professional help for emotional difficulties? Y/N

## Provide details for all "yes" answers:

\_\_\_\_\_  
\_\_\_\_\_

## Do you have: (Circle all that apply)

**Asthma**      Mild      Moderate      Severe      Exercise-induced

**Allergies** Food \_\_\_\_\_ Medication \_\_\_\_\_ Other \_\_\_\_\_

**Diabetes**      Type I      Type II

**Seizure disorder (describe):** \_\_\_\_\_

**Use an EPI Pen/EPI Pen Jr.** Yes ☑ No ☑

If YES, please attach a doctor's order permitting emergency use of pen.

Other (describe):

\_\_\_\_\_  
\_\_\_\_\_

## Please list any current Prescription Medications:

\_\_\_\_\_

## CONSENT TO TREAT

I grant to Hockey Essentials medical personnel permission to provide medical care for conditions that arise during participation in Hockey Essentials camps. (Every effort will be made to contact parents/guardians for specific permission if general anesthetic is indicated.) I hereby authorize the administration of whatever medical or surgical treatment may, in the judgment of the physician, be necessary and advisable for my child.

Child's name \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_

Date: \_\_\_\_\_

## AUTHORIZATION AND CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child

\_\_\_\_\_  
(Name)

However, if I cannot be reached I hereby authorize **Nutley Clifton Hockey Club (NCHC)** to transport my child to the

\_\_\_\_\_ Hospital (or nearest hospital)  
(Name)

## EMERGENCY RELEASE FORM

In case of emergency give names of persons who can be called and are authorized to pick-up your child if we cannot reach a parent:

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## INSURANCE INFORMATION

(Fill out for Day Camp Only)

Policyholder: \_\_\_\_\_ Policy holder D.O.B.: \_\_\_\_\_

Insurance company name: \_\_\_\_\_

Insurance company address: \_\_\_\_\_