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|  | **George Bray Sports Association Inc.****Player Profile** | *Team Assigned Current Year* |

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| **PLAYER INFORMATION** |
| **LAST NAME**  |       | **FIRST NAME**  |       |
| **ADDRESS**  |       |
| **CITY**  |       | **POSTAL CODE**  |       |
| **PRIMARY PHONE**  |       | **ALTERNATE PHONE**  |       |
| **EMAIL ADDRESS**  |       |
| **DATE OF BIRTH** (MONTH/DAY/YEAR) |       **AGE**       |
| **PARENT OR GUARDIAN – FIRST AND LAST NAME** |       |

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| **EMERGENCY CONTACT** |
| **EMERGENCY CONTACT** |       | **RELATIONSHIP** |       |
| **EMERGENCY PHONE** |       | **ALTERNATE PHONE** |       |

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| **LIVING ARRANGEMENTS** (CHECK ONE) |
|  | **PARENTAL HOME** |  | **CAREGIVER/GUARDIAN** |  | **GROUP HOME** |  | **INDEPENDENT** |
|  | **SUPPORTED INDEPENDENT LIVING** |
| **IEP RECEIVED**  |  | **Yes** |  | **No** |  | **Approved for Paying at GSBA** |

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| **DIVISION ASSIGNED** |
|  | **NEW** | **PREVIOUS TEAM:**       **CURRENT TEAM:**       |
|  | **FUNDAMENTALS** |  | **JUNIOR** |  | **INTERMEDIATE** |  | **SENIOR** |  | **HOCKEY SCHOOL** |
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| **MEDIA** |
|  | ***YES***, I allow photos to be taken of me throughout the season and at any events, and I allow them to be used in George Bray Sports Association publications. |
|  | ***NO*,** I do not allow photos to be taken of me throughout the season or at any events, and I do not allow them to be used in George Bray Sports Association publications |

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| **PLAYER WAIVER** |
| By **initialling here**, I confirm that I have read and signed the *Player Waiver form*        |

**Please note all information provided on this form is for the sole use of the George Bray Sports Association and will not be shared with anyone unless required by medical staff in the case of an emergency.**

 **PLAYER’S NAME:**

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| **PLAYER HEALTH HISTORY AND DIAGNOSIS INFORMATION** |
| **Doctor’s Name** |       | **Phone Number** |       |
| **Disability Diagnosis** |       |
| **Check all applicable boxes and provide explanation of special conditions** |
| **Special Condition** | **✓** | **Explanation**  |
| **Learning** |  |       |
| **Developmental** |  |       |
| **Behavioural** |  |       |
| **Physical** |  |       |
| **Visual** |  |       |
| **Hearing** |  |       |
| **Allergies** |  |       |
| **Health**  |  | *(Diabetes, asthma, heart, seizures, shunts, etc.)*      |
| **Communication** |  | *(Following directions, asking for assistance, processing, social, etc.)*      |
| **Down Syndrome** | Date of last Atlantoaxial dislocation x-ray (mm/dd/yyy)       X-ray result (check one) Negative  Positive (If positive, you are required to complete an Atlantoaxial Instability Release form) |

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| **MEDICATION REQUIREMENTS** |
| Player requires *no medication* (**check if applicable**) |  |  |
| Medication |       | Dosage |       | Time given |       |
| Medication |       | Dosage |       | Time given |       |
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| **SIGNATURE** |
| Form completed by (**please print**) |       |
| Relationship to Player  |       |
| **Signature** *Electronic signature above certifies all information is correct and accurate to the best of my knowledge.* | **Date**        |