George Bray Sports Association Inc.
Player Profile

Team Assigned *Current Year*

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	

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

LIVING ARRANGEMENTS (CHECK ONE)			
☐ **PARENTAL HOME**	☐ **CAREGIVER/GUARDIAN**	☐ **GROUP HOME**	☐ **INDEPENDENT**
☐ **SUPPORTED INDEPENDENT LIVING**			
IEP RECEIVED YES ☐ NO ☐	Approved for playing at GBSA ☐		

DIVISION PREVIOUSLY ASSIGNED				
NEW ☐	**TEAM LAST YEAR**			
☐ **FUNDAMENTALS**	☐ **JUNIOR**	☐ **INTERMEDIATE**	☐ **SENIOR**	☐ **HOCKEY SCHOOL ONLY**

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

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: _____

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)	

MEDICATION REQUIREMENTS					
Player requires *no medication* (**check if applicable**) ☐					
Medication		Dosage		Time given	
Medication		Dosage		Time given	
Medication		Dosage		Time given	
Medication		Dosage		Time given	
Medication		Dosage		Time given	

SIGNATURE	
Form completed by (**please print**)	
Relationship to Player	
Signature *By signing, I certify that all information on this form is correct and accurate to the best of my knowledge*	**Date**