



Medical Form

Please fill in this record as accurately and neatly as you can for your son or daughter.

Name of Athlete _____ Date of Birth _____
mm/dd/yy

Address _____ Athlete's 9 digit Medical No. _____

City _____ Province _____ Postal Code _____

Name of parent/guardian _____ Work Telephone _____

Cell Telephone _____ Home Telephone _____

Emergency Contacts

	<u>Name</u>	<u>Work Telephone Number</u>	<u>Home Telephone Number</u>
1.	_____	_____	_____
2.	_____	_____	_____

Name of family doctor _____ Telephone _____

Please list any food or drug allergies

Has your son/daughter been recently exposed to any communicable disease? Yes No

If yes, please list _____

Should medication be taken regularly? Yes No For what? _____

Please list medication(s) _____ How often? _____

Nervous habits? Yes No

Particular fears? Yes No

Does your child sleepwalk? Yes No

Additional Information

I verify that the above information for the named athlete is up-to-date and accurate. By signing this form, I am granting permission to seek medical attention for my son/daughter as required.

Parent's/Guardian's Signature

Date