

# MEDICAL FORM

Please fill in this record as accurately and as neatly as you can for your son or daughter. It will be on hand at all times for our immediate referral should an emergency or mishap occur.

Name of athlete \_\_\_\_\_ Date of birth (mm/dd/yy) \_\_\_\_\_

Address \_\_\_\_\_ Athlete's 9 digit Medical # \_\_\_\_\_

City \_\_\_\_\_ Family 6 digit Medical # \_\_\_\_\_

Province \_\_\_\_\_ Postal code \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Work telephone \_\_\_\_\_

Home telephone \_\_\_\_\_

## Emergency Contacts

Name	Work telephone #	Home telephone #
1. _____	_____	_____
2. _____	_____	_____

Name of family doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Please list any food or drug allergies \_\_\_\_\_

Has athlete 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 ? \_\_\_\_\_

Enuresis (bed wetting) Any record of this at home ?  Yes  No

Nervous habits ?  Yes  No

Particular fears ?  Yes  No

Does your child sleepwalk ?  Yes  No

## Additional information

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

I verify that the above information is up-to-date and accurate.

\_\_\_\_\_  
Parent's/Guardian's signature

\_\_\_\_\_  
Date