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 ____________________

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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

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

____________________ Parent's/Guardian's signature

____________________ Date