



EMERGENCY MEDICAL INFORMATION

Name _____

Last First Middle

Address _____

Postal Code _____ Phone Number _____

Date of Birth _____ A.H.C.# _____

Additional Medical Coverage _____

Next of Kin _____ Relationship _____

Address, same as above or _____

Phone Number, same as above or _____

Family Doctor _____ Phone Number _____

RELEVANT MEDICAL HISTORY

Medications _____

Allergies (Drugs, Antibiotics) _____

Allergies (Food/Beverage) _____

Date of Last Tetanus Shot

Previous Injuries _____

Major Operations

Contact Lenses: Yes _____ No _____ Type _____

Describe any medical problems that the coaching staff of this team should be aware eg. epilepsy, diabetes, etc.

I, THE UNDERSIGNED PARENT (GUARDIAN) HEREBY GIVE MY PERMISSION FOR THE COACH, ASSISTANT COACH, MANAGER OR TRAINER TO AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS MAY BE REQUIRED.

SIGNED _____