EMERGENCY MEDICAL INFORMATION AND CONSENT FORM

Athlete Name:____

Athlete date of Birth: day/month/year____________

EMERGENCY CONTACT INFORMATION

PARENT/GUARDIAN #1:
NAME:_______________________________________**Relationship**:______________________
PHONE:
Home_____________________**Cell:**____________________**Work**_________________________

ADDRESS:____

CITY/PROV____**POSTAL CODE**_______________

EMAIL ADDRESS____

PARENT/GUARDIAN #2:
NAME:_______________________________________**Relationship**:______________________
PHONE:
Home_____________________**Cell:**____________________**Work**_________________________

ADDRESS:____

CITY/PROV____**POSTAL CODE**_______________

EMAIL ADDRESS____

ALTERNATE EMERGENCY CONTACT:
NAME:_______________________________________**Relationship**:______________________
PHONE:
Home_____________________**Cell:**____________________**Work**_________________________

ADDRESS:____

CITY/PROV____**POSTAL CODE**_______________

EMAIL ADDRESS____

EMERGENCY MEDICAL CONSENT

I hereby authorize emergency medical or surgical treatment for myself or my son/daughter/ward if such treatment is required and the assigned emergency contact cannot be reached for authorization.
If the athlete is under 18, a parent or guardian must sign on their behalf.
Signature: ____________________________________Date: ________________
Please PRINT Name and Relationship to athlete (Self, Parent, Guardian?)
____
Please complete medical information on the next page:

MEDICAL INFORMATION

Athlete Name: ____
PROVINCIAL HEALTH CARD #______________________________________
DOCTORS NAME & PHONE #____
OUT OF PROVINCE/COUNTRY ADDITIONAL HEALTH PLAN:
COMPANY____________________________________**POLICY#**______________________
INSURANCE COMPANY
PHONE#____

HAVE YOU HAD A TETANUS SHOT IN THE LAST 10 YEARS? __________ **DATE of SHOT** ________________

DO YOU REQUIRE ANY REGULAR MEDICATION?__________**IF YES INDICATE TIME AND DOSAGE BELOW.**

MEDICATION	WHEN TO BE TAKEN	PURPOSE	SIDE EFFECTS

DO YOU HAVE ATHSMA? [ ] YES [ ] NO
ATHSMA TRIGGER FACTORS
____

DO YOU HAVE ANY ALLERGIES? [ ] YES [ ] NO
IF SO WHAT ARE THEY, WHAT IS YOUR REACTION, AND WHAT MEDICATIONS DO YOU USE FOR THEM, AND WHEN?
____
____
____

DO YOU USE ANY SPECIAL NEED DEVICES SUCH AS GLASSES, CONTACT LENS, KNEE BRACES, HEARING AIDS ETC…? IF SO WHAT ARE THEY ? (BE SPECIFIC)
____
____
____
____

ARE THERE ANY OTHER MEDICAL ISSUES THAT WE SHOULD BE MADE AWARE OF?
____
____
____
____
____

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