



Skater Medical Information

Name: _____

Date of Birth: Day _____ Month _____ Year _____

Address: _____

Phone: _____ Provincial Health Care Number _____

Parent's Name: _____ Parent's Name: _____

Cell Numbers: Mother _____ Father _____

Person to contact in case of emergency, if parents are not available.

Name: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

| Circle the appropriate response below pertaining to your child | | |
|--|----|---------------------------------|
| Yes | No | Previous history of concussions |
| Yes | No | Epilepsy |
| Yes | No | Wears glasses |
| Yes | No | Are lenses shatterproof |
| Yes | No | Wears contacts |
| Yes | No | Wears dental appliance |
| Yes | No | Asthma |
| Yes | No | Diabetes |
| Yes | No | Medications |
| Yes | No | Allergies |
| Yes | No | Wears a medical alert bracelet |

Skater Medical Information page 2

Please give details below if you answered "Yes" to any of the above questions.

(use the back of page if necessary)

Medications: _____

Allergies: _____

Last Tetanus Shot: _____

Any medical condition or injury should be checked by your physician before participating in a speed skating program. I understand that it is my responsibility to keep the coaches advised of any change in the above information as soon as possible and that in the event no one can be contacted, coaches or club designates will take my child to hospital if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination and necessary treatment of my child.

I also authorize the release of information to appropriate people(coach, physician) as deemed necessary.

Date: _____ Signature of Parent or Guardian: _____