

Appendix 10 - Athlete Medical Data Record

Complete this form for each of your athletes.

NOTE: IF THE REQUESTED INFORMATION IS NOT PROVIDED, THE ATHLETE WILL NOT BE PERMITTED TO PARTICIPATE IN THE ACTIVITY.

PLEASE PRINT CLEARLY IN INK OR TYPE

NAME OF PARTICIPANT			DATE OF BIRTH (D/M/Y)
ADDRESS:			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NO.
NAME OF PARENT/GUARDIAN (IF < 18 YEARS OLD.)		RELATIONSHIP	TELEPHONE NO.
PLEASE LIST ALL EXISTING MEDICAL CONDITIONS/ALLERGIES (INCLUDING FOOD) OF THE PARTICIPANT			
PLEASE LIST ANY MEDICATIONS REQUIRED (TYPES/TIMES REQUIRED/STORAGE REQUIREMENTS/ADMINISTRATION PROCEDURES)			
HEALTH CARD NUMBER (INCL. VERSION CODE)	NAME OF FAMILY PHYSICIAN	TELEPHONE # OF PHYSICIAN	
<p>I hereby give permission for emergency medical treatment to be administered to my son/daughter, as may be determined in the reasonable discretion of his/her personal coach or program supervisor. It is understood that whenever reasonably possible, relatives will be contacted and informed of the problem, diagnosis, treatment required and anticipated medical results.</p> <p>I understand that it is my responsibility to ensure that the information on this form is kept current and I will notify the coach of any changes immediately.</p>			
SIGNATURE OF PARTICIPANT (OR PARENT/GUARDIAN IF PARTICIPANT IS UNDER THE AGE OF 18)			DATE (D/M/Y)