



MEDICAL FORM

Name: _____ Birth Date: D _____ M _____ Y _____
Address: _____ Email: _____
Postal Code: _____ Telephone #: _____
Mother's Name: _____ Father's Name: _____
Business Telephone #: Mother _____ Father _____

Contact person in case of accident or emergency if parents are not available:

Name: _____ Telephone #: _____
Address: _____
Doctor's name: _____ Telephone #: _____
Dentist's name: _____ Telephone #: _____

Please circle the appropriate response below pertaining to your child:

- | | |
|---|----------|
| 1. Asthma | Yes / No |
| 2. Wears glasses | Yes / No |
| 3. Wears shatter-proof glasses | Yes / No |
| 4. Allergies | Yes / No |
| 5. Diabetic | Yes / No |
| 6. Epileptic | Yes / No |
| 7. Hearing problem | Yes / No |
| 8. Medication being taken at home | Yes / No |
| 9. Has had injuries requiring medical attention in the past year | Yes / No |
| 10. Has had an illness lasting more than one week | Yes / No |
| 11. Heart condition | Yes / No |
| 12. Wears a medical alert bracelet or necklace | Yes / No |
| 13. Receiving counseling from an outside source | Yes / No |
| 14. Does your child have any health problem that would interfere with the expected level of participation | Yes / No |
| 15. Has been in the hospital except for a tonsillectomy in the past year | Yes / No |

Please give details below if you answered 'Yes' to any of the above:

I understand it is my responsibility to keep the team management advised on any changes in the above information as soon as possible and in the event no one can be contacted, team management staff will admit my child to the hospital if deemed necessary. I hereby authorize the physician and nursing staff of any 'emergency unit' to undertake examination, investigation, and necessary treatment of my child.

Date: _____ Signature of Parent or Guardian: _____

All information above will be kept in strict confidence by team staff.