MAPLE RIDGE SKATING CLUB

Medical Information Sheet

Name:

Date of birth: Day Month Year

Address:

Postal Code:

Telephone: Cell:

Provincial Health Number (optional):

Parent/Guardian #1: Name:

Phone number:

Parent/Guardian #2: Name:

Phone number:

Alternate emergency contact (if parents are not available)

Name:

Relationship to skater:

Telephone: Cell:

Doctor's name:

Telephone:

Dentist's name:

Telephone:

Date of last complete physical examintation:

Before a skater participates in a program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Medication	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Previous history of concussions	☐ Yes	☐ No
Fainting or seizure during or after physical activity	☐ Yes	☐ No
Near fainting or Brownouts	☐ Yes	☐ No
Seizures and/or epilepsy	☐ Yes	☐ No
Wears glasses	☐ Yes	☐ No
Are lensess shatterproof	☐ Yes	☐ No
Wears contact lenses	☐ Yes	☐ No
Wears dental appliance	☐ Yes	☐ No
Hearing problem	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Trouble breathing during exercise	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No

Palpitations or Racing Heart	☐	Yes	☐	No	
Family history of heart disease	☐	Yes	☐	No	
Family history of unexpected death during physical activity	☐	Yes	☐	No	
Family history of unexplained death of a young person	☐	Yes	☐	No	
Diabetes	☐	Yes	☐	No	Type 1 _____ Type 2_____
Wears medical information bracelet/necklace	☐	Yes	☐	No	For what purspose?
Has had an illness that lasted more than a week and required medical attention in the past year	☐	Yes	☐	No	
Been admitted to hospital in the last year	☐	Yes	☐	No	
Surgery in the last year	☐	Yes	☐	No	
Prestently Injured	☐	Yes	☐	No	Injured body part
Vaccination up to date	☐	Yes	☐	No	Date of last Tetanus shot:

Please give details if you answered "yes" to any of above. (Use separate sheet if necessary)

Medications:		Recent Injuries:	
Allergies:		Any information not covered above:	
Medical conditions:			

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary

Date:		Signature of Player:	
Date:		Signature of Parent/Guardian:	

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