MEDICAL INFORMATION

PLEASE PRINT CLEARLY

Athlete Name:					
Birth Date	(dd/mm/yy)	Age		Male ☐	Female ☐
Address					
	Street				
	City	Province		Postal	
Medicare Number					

Parents Name			
Address			
	Street		
	City	Province	Postal
Phone #'s			
	Home	Work	Cell

Family Doctor		
	Name	Phone

Health History		**Details:**
Allergies	Yes ☐ No ☐	_____
Asthma (Respiratory)	Yes ☐ No ☐	_____
Blackouts/Fainting	Yes ☐ No ☐	_____
Chest pain	Yes ☐ No ☐	_____
Diabetes	Yes ☐ No ☐	_____
Epilepsy	Yes ☐ No ☐	_____
Hearing Disorder	Yes ☐ No ☐	_____
Heart Condition	Yes ☐ No ☐	_____
Recurring Headaches	Yes ☐ No ☐	_____
Seizures	Yes ☐ No ☐	_____
Glasses	Yes ☐ No ☐	_____
Contact Lenses	Yes ☐ No ☐	_____
Injuries (specify)	Yes ☐ No ☐	_____
Medications (specify)	Yes ☐ No ☐	_____
Other (including recent surgery)	Yes ☐ No ☐	_____

Other:_____