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: _____