

**SALTFLEET FIGURE SKATING CLUB INC.
SKATER MEDICAL INFORMATION SHEET 2009-2010**

NAME: _____

DATE OF BIRTH: Day _____ Month _____ Year _____

ADDRESS: _____

POSTAL CODE: _____ PHONE NUMBER: _____

PROVINCIAL HEALTH NUMBER: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

BUSINESS/CELL PHONE NUMBERS (where you can be reached while your child is at the arena)

MOTHER'S #: _____ FATHER'S #: _____

Person to contact in case of accident or emergency, if parents are not available.

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

DOCTOR'S NAME: _____ PHONE NUMBER: _____

DENTIST'S NAME: _____ PHONE NUMBER: _____

Please circle the appropriate response below pertaining to your child.

Yes No	Previous history of concussions	Yes No	Fainting episodes during exercise
Yes No	Epileptic	Yes No	Trouble breathing during exercise
Yes No	Wears glasses	Yes No	Medication
Yes No	Are lenses shatterproof?	Yes No	Allergies
Yes No	Wears contact lenses	Yes No	Wears a medic alert bracelet/necklace
Yes No	Wears dental appliance	Yes No	Surgery in the last year
Yes No	Hearing problem	Yes No	Has been in hospital in the last year
Yes No	Asthma	Yes No	Has had injuries requiring medical attention in the past year
Yes No	Diabetic		
Yes No	Heart Condition	Yes No	Presently injured

Please give details below if you answered "Yes" to any of the above items.

Please turn over.....

Please fill in as necessary:

Medications: _____

Allergies: _____

Medical Conditions: _____

Recent Injuries: _____

Last Tetanus Shot: _____

Any information not covered above: _____

*Any medical condition or injury problem should be checked by your physician before participating in the skating program.

I understand that it is my responsibility to keep the Club management advised of any change in the above information as soon as possible and that in the event no one can be contacted, the Executive Committee will take my child to the hospital/MD. 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 Parent or Guardian: _____

Printed name of Parent or Guardian: _____