

Saskatchewan Speed Skating MEDICAL INFORMATION FORM

Event: _____

In order to minimize risk and to provide you with medical care, it is very important that you fill this form out carefully, completely and legibly. If you are uncertain about any question, please consult your family physician.

Name (last) _____ (first) _____

Club _____

Phone _____ Birth Date (DD/MM/YYYY) _____

Address _____ Postal Code _____

Provincial Medical Insurance Number _____

Additional insurance (Blue Cross, GMS) _____

Next of kin Name _____

Relationship _____

Home Phone _____ Work Phone _____

Other contact Name _____

Relationship _____

Home Phone _____ Work Phone _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I authorize emergency medical and/or dental treatment or surgical operation for myself, son or daughter if such treatment is deemed necessary .

Name of athlete or Parent/Guardian _____

Signature of athlete or Parent/Guardian _____ Date _____

(If athlete is not of legal age)

Name of Witness (please print) _____

Signature of Witness _____ Date _____

You have a right to privacy of any medical information. ALL MEDICAL INFORMATION IS CONFIDENTIAL AND WILL BE VIEWED ONLY BY THE CHAPERONE, COACH (OR THEIR DESIGNATE), AND ATTENDING MEDICAL STAFF.

MEDICAL HISTORY

YES NO
(please

In the past 12 months -
check)

Have you had or do you now have high or low blood pressure ? _____

Have you had or do you have epilepsy or fits ? _____

Have you had a concussion or been "knocked out"? _____

Have you been treated for an infectious disease ? _____

If yes, which disease ? _____

Have you ever had to stay in hospital overnight ? If YES, what for ? _____

Have you ever had surgery ? If YES, what for ? _____

Have you ever broken any bones ? If YES, which bones ? _____

Do you wear contact lenses or glasses ? _____

Do you have any pins/plates/screws in your body from bone or joint surgery ? _____

If so, where ? _____

Do you wear any dental appliances such as braces or a plate ? _____

Do you have any food or other allergies e.g. (nuts, wasps) ? If YES, please list. _____

Are you taking any prescription or non-prescription medications ? _____

If YES, please list. _____

Do you have any allergies to medications ? If YES, please list. _____

When were your immunizations last updated ? (Including tetanus) (month/year)
_____/____

Circle any areas which you have injured in the past 12 months

- | | | | | | | | |
|------|-------|-------|-------|-----------|----------|------|------|
| Hand | Elbow | Neck | Hip | Shin/Calf | Wrist | Knee | Foot |
| Arm | Chest | Thigh | Ankle | Forearm | Shoulder | Back | Head |

FAMILY HISTORY

Has any of your family had any of these illnesses? If YES, circle the illness.

Diabetes Disease	Allergies	Arthritis	Neurological Disorders	Gout	Heart
High Blood Pressure Disease		High Cholesterol	Bleeding Problems		Kidney
Mental Illness		Sickle Cell Anemia	Aneurysm		

Do you have any other health concerns that have not been mentioned above?
