

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 check)
In the past 12 months -		
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	Allergies	Arthritis	Neurological Disorders	Gout	Heart Disease
High Blood Pressure		High Cholesterol	Bleeding Problems		Kidney Disease
Mental Illness		Sickle Cell Anemia	Aneurysm		

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