MEDICAL FORM

Name: _____ Birth Date: D _____ M _____ Y _____
Address: _____ E-mail: _____
Postal Code: _____ Telephone #: _____
Mother's Name: _____ Father's Name: _____
Business Telephone #: Mother _____ Father _____

Contact person in case of accident or emergency if parents are not available:
Name: _____ Telephone #: _____
Address: _____
Doctor's Name: _____ Telephone #: _____
Dentist's Name: _____ Telephone #: _____

Please circle the appropriate response below pertaining to your child:

1.	Asthma	Yes / No
2.	Wears glasses	Yes / No
3.	Wears shatter-proof glasses	Yes / No
4.	Allergies	Yes / No
5.	Diabetic	Yes / No
6.	Epileptic	Yes / No
7.	Hearing problem	Yes / No
8.	Medication being taken at home	Yes / No
9.	Has had injuries requiring medical attention in the past year	Yes / No
10.	Has had an illness lasting more than one week	Yes / No
11.	Heart condition	Yes / No
12.	Wears a medical alert bracelet or necklace	Yes / No
13.	Receiving counseling from an outside source	Yes / No
14.	Does your child have any health problem that would interfere with the expected level of participation	Yes / No
15.	Has been in the hospital except for a tonsillectomy in the past year	Yes / No

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

_____
_____
_____
_____
_____
_____

I understand it is my responsibility to keep the team management advised on any changes in the above information as soon as possible and in the event no one can be contacted, team management staff will admit my child to the hospital if deemed necessary. I hereby authorize the physician and nursing staff of any 'emergency unit' to undertake examination, investigation, and necessary treatment of my child.

Date: _____ Signature of Parent or Guardian: _____

All information will be kept in strict confidence by team staff.