



## Medical Information Card

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact e-mail (Print Clearly): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Emergency Contact Number: \_\_\_\_\_

Allergies/ Medical Conditions: \_\_\_\_\_

Previous Injuries: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Policy and Number: \_\_\_\_\_

Health Card Number: \_\_\_\_\_

As the parent/legal guardian of the above listed individual who is below the legal age of majority, I hereby give permission for them to be given any medical treatment deemed necessary should they be unable to contact me directly in the event of emergency. I also state that all of the information listed in this form is corrected to the best of my knowledge.

\_\_\_\_\_  
Athletes Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date