Skater's Medical Information Form

(Confidential)

Name: ____

Address: ________________________ Phone: ________________________

Health Card #:____________________ Date of Birth: ___________________

Mother: _________________________ Address: _______________________

Phone: __________________________ Cell: __________________________

Father: _________________________ Address: _______________________

Phone: __________________________ Cell: __________________________

Alternate Contact Name: _____________________ Phone: ______________

Relationship to Skater: _______________________

Medical History

Injuries: - check appropriate boxes if you have had any of the following injuries:

() Concussions	() Wrist	() Hip	() Neck	() Fingers
() Knees	() Ribs	() Elbow	() Ankles	() Back
() Shoulder	() Feet	() Fractures	() Dislocations	() Other (list):

Additional information on injury(ies):____

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____

Allergies:

Environmental (e.g. dust, smoke, hay fever, animals, insects, etc), food and medication allergies:

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____

Medications (list):____

____

Medications:

Prescriptions (list):____

I declare that the information I have submitted on this medical form is a complete and accurate disclosure of my medical history.

Athletes Signature: _______________________ Date: _______________________________

If the athlete signing this form is under 18 years of age the form must also be signer by a parent or guardian.

Parent/Guardian Signature: ________________________ Date: _________________________________