MEDICAL INFORMATION SHEET

The purpose of this form is to advise emergency personnel of any pre-existing medical situations, personal histories, or vital care information, should the need for emergency care be required and the patient requiring care is unable to communicate the information. Once completed this form should be sealed in an envelope and that envelope placed in the team reps first aid kit. If the need for care arises, it is understood and expected that the contents will be retrieved by the patient's team rep and viewed by the attending care providers.

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____ Telephone: (____) _____

First emergency contact:

Name: _____ Telephone: _____
Relationship: _____

Second emergency contact (if unable to reach first contact):
Name: _____ Telephone: _____
Relationship: _____
Doctor's Name: _____
Dentist's Name: _____ Telephone: (____) _____
Telephone: (____) _____

Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes	No	Wears glasses
Yes	No	Wears contact lenses
Yes	No	Wears dental appliance
Yes	No	Hearing problem
Yes	No	Asthma
Yes	No	Trouble breathing during exercise
Yes	No	Fainting episodes during exercise
Yes	No	Heart Condition
Yes	No	Diabetic – Type 1_____ Type 2_____
Yes	No	Epileptic
Yes	No	Medication
Yes	No	Allergies
Yes	No	Wears a medical information bracelet or necklace For what purpose? _____
Yes	No	Has any health problem that would interfere with officiating
Yes	No	Has had an illness that required medical attention in the past year
Yes	No	Has had injuries requiring medical attention in the past year
Yes	No	Has been admitted to hospital in the last year
Yes	No	Surgery in the last year
Yes	No	Presently injured. Injured body part: _____
Yes	No	Previous history of concussions
Yes	No	Vaccinations up to date
Yes	No	Hepatitis B vaccination

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Please give details if you answered "Yes" to any of the above. Use separate sheet if necessary

_____

_____

Medications: _____
Allergies: _____
Medical conditions: _____
Recent injuries: _____
Date of last Tetanus Shot: _____
Any information not covered above: _____

I understand that it is my responsibility to keep this form updated with current information, as it will be used in cases of my incapacitation. In the event of a medical emergency and that no one can be contacted, my officiating colleagues will arrange to take/send me to the hospital or a physician if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of me.

I also authorize release of information to appropriate people (EMS responder, physician) as deemed necessary.

Date:_____ Signature of Participant: _____

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which it is collected and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Ac