Saskatchewan Speed Skating Medical Information Form 2012-2013 Season

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. This form will cover all events for the season only requiring you to fill this out once every skating season.

Last Name		First Name	
Club			
Phone Number	(306)	Birth Date (DD/MM/YYYY)	
Street Address		City		Prov	
		Postal Code	
Provincial Medical Insurance Number			
Additional Insurance (Blue Cross, GMS)			

Next of Kin

Name					
Relationship					
Home Phone	(306)	Work Phone	(306)	Cell Phone	(306)

Other Contact

Name					
Relationship					
Home Phone	(306)	Work Phone	(306)	Cell Phone	(306)
Family Physician		Phone Number	(306)		
Family Dentist		Phone Number	(306)		

MEDICAL HISTORY

	Yes	No
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 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.		

Circle or highlight any areas, which you have injured in the past 12 months

Hand	Elbow	Neck	Hip	Shin/Calf	Wrist	Knee	Foot	Arm	Chest
Back	Ankle	Forearm		Shoulder	Head	Thigh			

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I authorize emergency medical and/or dental treatment or surgical operation for son, daughter or myself if such treatment is deemed necessary.

Name of athlete or Parent/Guardian			
Signature of athlete or Parent/Guardian (If athlete is not of legal age)		Date	
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. If any important medical information has changed over the course of the year it is your responsibility to update this form and inform SASSA.