

# MEDICAL INFORMATION FORM

Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Date of Birth \_\_\_\_\_ B.C. Care Card Number \_\_\_\_\_

Contact Person(s) in event of emergency: \_\_\_\_\_

(Parent/Guardian)

Day Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Other (Cell): \_\_\_\_\_

Contact Person if there is no answer at the above numbers:

\_\_\_\_\_

Day Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Family Doctor: Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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

\_\_\_\_\_

Please give relevant medical information with respect to:

Medications: \_\_\_\_\_

Are they carried by your child? \_\_\_\_\_

Are they administered by your child? \_\_\_\_\_

Allergies: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the event that my child requires immediate medical treatment, I hereby authorize the  
leaque officials to seek such treatment:

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

I consent to this form being kept in the Umpire Change Room so it can be accessed for  
medical emergencies.