

SPRINGS CHRISTIAN ACADEMY MEDICAL FORM



This form must be completed prior to the participant's involvement in each interscholastic sport. The rationale is to provide coaches with the most up-to-date medical information for your son/daughter. It will be readily available at the interscholastic site for our immediate referral if an emergency or mishap occurs.

Player's Name: _____ Gender: _____

Date of Birth: Day _____ Month _____ Year _____

Address: _____ Postal Code: _____

Telephone: _____

E-mail: _____ Mother's Name: _____

_____ Father's Name: _____

Business Phone Mother: _____ Business Phone Father: _____

_____ Additional Phone Numbers (cell): _____

Person to contact in case of emergency, if parents cannot be contacted.

Name: _____ Phone: _____

Address: _____

Manitoba Medical Number (6 digits) _____ PIN (9 digits) _____

Extended Health Coverage? Yes _____ No _____

If yes, who is the carrier? _____

Policy number: _____

Note: Manitoba Medical does not cover dental costs or ambulance, contact Blue Cross for extended coverage.

Doctor's Name: _____ Phone Number: _____

Date of Last Physical Examination: _____

Dentist's Name: _____ Phone Number: _____

Sport: _____

Please circle the appropriate response below pertaining to your child:

- | | | |
|-----|----|--|
| Yes | No | Previous history of concussion(s) |
| Yes | No | Fainting spells during exercise |
| Yes | No | Epileptic |
| Yes | No | Wears glasses |
| Yes | No | Wears contact lenses |
| Yes | No | Wears a dental appliance |
| Yes | No | Hearing problem |
| Yes | No | Asthma/exercise induced asthma |
| Yes | No | Requires the use of an 'inhaler' |
| Yes | No | Trouble breathing during exercise |
| Yes | No | Heart condition |
| Yes | No | Diabetic |
| Yes | No | Has had an illness lasting more than a week in the last 6 months |
| Yes | No | Is taking some form of medication |
| Yes | No | Has allergies |
| Yes | No | Is allergic to penicillin or any form of drug |
| Yes | No | Wears a medical alert bracelet |
| Yes | No | Has body piercing |
| Yes | No | Has had surgery in the last year |
| Yes | No | Has been in the hospital in the last year |
| Yes | No | Has had a serious injury from an accident in the last year (sport / otherwise) |
| Yes | No | Is presently injured and receiving treatment |
| Yes | No | Is presently injured and not receiving treatment |
| Yes | No | Has had a tetanus shot in the last year |
| Yes | No | Smokes |

Please give details below if you answered YES to any of the preceding questions.

Is there any other medical information not covered above which the coaches should be aware of?

Note: Any medical condition or injury problem should be checked by the student's physician prior to his/her participating in any program.

As the parent/guardian of this athlete I understand that it is my responsibility to advise the coaches of any changes in the above information as soon as possible.

I hereby authorize the coach(es) to take my child to the hospital/physician if she/he/they deem it necessary.

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

I authorize the release of this medical information to appropriate individuals (paramedics, physicians or nurses) if deemed necessary.

Date: _____ Signature of

Parent/Guardian: _____

Signature of Participant: _____