Emergency & Medical Information and Consent Form

BIATHLON ONTARIO

ATHLETE NAME	AGE
EVENT	EVENT DATE (MM-DD-YY to MM-DD-YY)

Emergency Contact Information

PARENT/GUARDIAN #1			RELATIONSHIP
PHONE (HOME)	PHONE (WORK)		PHONE (MOBILE)
ADDRESS			
CITY	PROV	POSTAL CODE	EMAIL ADDRESS
PARENT/GUARDIAN #2			RELATIONSHIP
PHONE (HOME)	PHONE (WORK)		PHONE (MOBILE)
ADDRESS			
CITY	PROV	POSTAL CODE	EMAIL ADDRESS
ALTERNATIVE EMERGENCY CONTACT			RELATIONSHIP
PHONE (HOME)	PHONE (WORK)		PHONE (MOBILE)
ADDRESS			
CITY	PROV	POSTAL CODE	EMAIL ADDRESS

Emergency Medical Consent

I hereby authorize emergency medical or surgical treatment for _____ if such treatment is required and the assigned emergency contact cannot be reached for authorization.

If the athlete is under 18, a parent or guardian must sign on their behalf.

Signature: _____ Date: _____

Please PRINT Name and Relationship to athlete (Self, Parent, Guardian):

_____

Medical Information

ATHLETE NAME		BIRTHDATE (MM-DD-YY)
PROVINCIAL HEALTH CARE CARD #	PROVINCE	EXPIRES
OUT OF PROVINICE/COUNTRY ADDITIONAL HEALTH PLAN – COMPANY	POLICY NUMBER	PHONE NUMBER
DOCTOR'S NAME		PHONE
CLINIC		
ADDRESS		

CITY	PROV	POSTAL CODE	EMAIL ADDRESS

Have you had a tetanus shot in the last 10 years? ☐	DATE OF LAST SHOT (MM-DD-YY)

Do you take any medication? ☐

MEDICATION	PURPOSE/TREATMENT FOR?	WHEN TO BE TAKEN?	ANY SIDE EFFECTS TO BE AWARE OF?

Do you have asthma? ☐

ASTHMA TRIGGER FACTORS, TREATMENT, MEDICATION

Do you have allergies? ☐ Do you have an Epi PEN? ☐

PLEASE STATE WHAT THEY ARE, WHAT IS YOUR REACTION, AND WHAT MEDICATIONS DO YOU USE FROM THEM AND WHEN

Do you use any special need devices such as glasses, contact lens, knee braces, hearing aids, etc.? (be specific)

Are there any other medical issues that we should be made aware of?

ALL INFORMATION CONTAINED IN THIS DOCUMENT WILL BE KEPT CONFIDENTIAL AND IS SOLELY FOR THE USE OF BIATHLON ONTARIO