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 official requiring care is unable to communicate the information. Once completed this form should be sealed in an envelope and that envelope placed in the official's equipment bag. If the need for care arises, it is understood and expected that the contents will be retrieved by the official's colleagues 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: _____ Telephone: (____) _____
Dentist's Name: _____ 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/my child 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/my child.

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

Date:_____ Signature of Participant: _____

(Parent or Guardian, if participant is under 18 years of age)

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 Act.