www.cpv3lacs.org

CLUB DE PATINAGE DE VITESSE DES TROIS-LACS

MEDICAL INFORMATION

PERSONAL INFORMATION

Surname		**Name**	
Address (Nº and street)	**City**		**Postal Code**
Birthday (dd/mm/yy)		**Medicare Nº**	
First parent's surname	**First parent's name**	**First parent's phone (home)**	**First parent's Phone (Cell / work)**
Second parent's surname	**Second parent's name**	**Second parent's phone (home)**	**Second parent's Phone (Cell / work)**

Persons to reach in case of emergency if the parents are not available:

Name	**Relationship**	**Phone (Cell/home/work)**
Name	**Relationship**	**Phone**

MEDICAL INFORMATION

Please tick off the appropriate answers.

	Yes	No		Yes	No
Asthma?	☐	☐	Presently injured?	☐	☐
Epileptic?	☐	☐	Injury requiring medical treatment during last year?	☐	☐
Diabetic?	☐	☐	Episodes of cerebral concussion?	☐	☐
Allergies?	☐	☐	Operation in the last year?	☐	☐
Cardiac problems?	☐	☐	Was sick for more than a week last year?	☐	☐
Hearing problems?	☐	☐	Wears glasses?	☐	☐
Respiratory problems during exercise?	☐	☐	If wear glasses, are they unbreakable?	☐	☐
Episodes of fainting during exercise?	☐	☐	Wears contact lenses?	☐	☐
Takes medication?	☐	☐	Wears a dental piece?	☐	☐
Wears a Medic Alert bracelet or collar?	☐	☐	Other (if so, give the details below)	☐	☐

Please fill the following table.

If you answered « yes » to one of the above questions, give more details here:	**Medications:**
	Allergies:
	Sickness:
	Injuries:
	Date of last tetanus vaccine:
	Date of last complete medical examination:
Please indicate here any other pertinent information :	

ACCEPTATION

All diseases or problems related to an injury should be checked out by a doctor before the practice of speed skating. The coach will reserve the right to demand a doctor's note. I understand that it is my responsibility to advise the club of all changes concerning the above information given as soon as possible and in the eventuality that it is impossible to reach the person responsible, the club will bring my child to the hospital or to the doctors if necessary. I, hereby, authorize the doctor and medical personal to examine and to proceed to the treatment necessary for my child. I also authorize that pertinent information be given to the appropriate persons (coach, medics, doctor) if necessary.

Date : _____ Parent or guardian signature: _____