



CLUB DE PATINAGE DE VITESSE DES TROIS-LACS

info@cpv3lacs.org

MEDICAL INFORMATION

PERSONAL INFORMATION

Surname		Name	
Address (N° and street)		City	Postal Code
Birthday (dd/mm/yy)		Medicare N°	
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?	<input type="checkbox"/>	<input type="checkbox"/>	Presently injured?	<input type="checkbox"/>	<input type="checkbox"/>
Epileptic?	<input type="checkbox"/>	<input type="checkbox"/>	Injury requiring medical treatment during last year?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	Episodes of cerebral concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	Operation in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac problems?	<input type="checkbox"/>	<input type="checkbox"/>	Was sick for more than a week last year?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	Wears glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If wear glasses, are they unbreakable?	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of fainting during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Wears contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Takes medication?	<input type="checkbox"/>	<input type="checkbox"/>	Wears a dental piece?	<input type="checkbox"/>	<input type="checkbox"/>
Wears a Medic Alert bracelet or collar?	<input type="checkbox"/>	<input type="checkbox"/>	Other (if so, give the details below)	<input type="checkbox"/>	<input type="checkbox"/>

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: _____