BOW VIEW RINGETTE ASSOCIATION:
Emergency Medical Information

Name: _____

Last **First** **Middle**

Address: _____

Postal Code: **Phone Number:** _____

Date of Birth: **AHC#:** _____

Additional Medical Coverage: _____

Next of Kin: **Relationship:** _____

Address, same as above or: _____

Phone Number, same as above or: _____

Family Doctor: **Phone Number:** _____

RELEVANT MEDICAL HISTORY

Medications: _____

Allergies (drugs, antibiotics): _____

Allergies (food/beverage): _____

Date of Last Tetanus Shot: _____

Previous Injuries: _____

Major Operations: _____

Contact Lenses: **Yes:** ☐ **No:** ☐ **Type:** _____

Describe any medical problems that the coaching staff of this team should be aware of (e.g., epilepsy, diabetes, etc.)

_____

_____

_____

_____

_____

I, THE UNDERSIGNED PARENT (GUARDIAN) HEREBY GIVE MY PERMISSION FOR THE COACH, ASSISTANT COACH, MANAGER OR TRAINER TO AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS MAY BE REQUIRED.

Signed: _____