



MEDICAL HISTORY (submit one per athlete)

ATHLETE'S NAME _____ DATE _____

PARTNER'S NAME (if applicable) _____ CATEGORY(IES) _____

FAMILY PHYSICIAN NAME _____ PHONE # _____

EMERGENCY CONTACT NAME _____ PHONE # _____

PROVINCIAL HEALTH CARD* _____
 (Number) (Version Code) (Province)

Please print clearly

MEDICAL HISTORY SUMMARY	Yes/No	Describe
*Have you had any surgery in the last 12 months?	<input type="checkbox"/> <input type="checkbox"/>	
*Has a doctor ever told you that you have heart or circulatory problems? (e.g. murmur, palpitations, irregular heart beat, high blood pressure, etc.)	<input type="checkbox"/> <input type="checkbox"/>	
Were you born without or have suffered the loss of a lung, kidney or other organ? If yes, what organ?	<input type="checkbox"/> <input type="checkbox"/>	
*In the last year, has a doctor ever denied or restricted your participation in sports for any reason? If yes, why?	<input type="checkbox"/> <input type="checkbox"/>	
*Do you know of any health reason why you should not participate in the above mentioned event?	<input type="checkbox"/> <input type="checkbox"/>	
Do you have any allergies? If yes, please specify.	<input type="checkbox"/> <input type="checkbox"/>	
Are you currently taking any medication?	<input type="checkbox"/> <input type="checkbox"/>	
*Are you currently wearing any type of protective equipment or bracing for any existing injury or condition (e.g. knee brace, helmet, etc.)?	<input type="checkbox"/> <input type="checkbox"/>	

Are you currently receiving regular rehabilitation treatment? Please specify below:		
Type of treatment (physiotherapy, massage, chiropractor, athletic therapy, etc.)	Name of provider	City and phone number of provider

Medical doctors' services on site are covered by the provincial health plans and will require a valid health card. Please bring your health card to the medical room when you require service or provide us with the information on this registration form and we will ensure that the medical clinic has it.

COMMENTS: _____



MEDICAL WAIVER

I, _____ (the undersigned), hereby agree that the relationship between myself and any attending physician, therapist or allied medical personnel in connection with the competition shall be governed by and constructed in accordance with the laws of the Province in which the competition is being held.

I acknowledge that the treatment/service performed in the Province in which the competition is being held and that the Courts of the Province in which the competition is being held shall have jurisdiction to entertain any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising from the treatment. I hereby agree that I will commence any such legal proceedings in the Province in which the competition is being held and only in that Province in which the competition is being held and hereby submit to the jurisdiction of the Courts of the Province in which the competition is being held.

I hereby state that, to the best of my knowledge, all of the answers on the preceding Medical History form are correct.

I have fully read and understood and agree to this waiver form.

Signature of Athlete

Date

Signature of Parent/Guardian at competition (*if athlete is under 19 years of age*)

Date

Signature of Witness

Date