CS Dieppe

Medical Form

Team : ______________________

LAST NAME ______________________ FIRST NAME ______________________

BIRTH DATE ______________________ AGE ______________________

STREET ADDRESS ______________________ CITY/TOWN ______________________

PROVINCE ______________________ POSTAL CODE ______________________

TEL. # (HOME) ______________________ TEL # (CELL) ______________________

EMAIL ______________________ EMAIL (2) ______________________

NONAME OF FAMILY DOCTOR ______________________ TEL # (DOCTOR) ______________________

MEDICARE # ______________________ ______________________

EMERGENCY CONTACT (1) ______________________ TEL # (EMERGENCY CONTACT 1) ______________________

EMERGENCY CONTACT (2) ______________________ TEL # (EMERGENCY CONTACT 2) ______________________

ALLERGIES & TREATMENT ____

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PERMISSION TO ADMINISTER			
	GRAVOL (NAUSEA)	◯YES	◯NO
	TYLENOL/ADVIL (FEVER, PAIN)	◯YES	◯NO
	BENADRYL (ALLERGIES)	◯YES	◯NO

OTHER INFOS : ____

SIGNATURE (PARENT) ______________________ DATE : ______________________

Authorisation:

I ______________________________________ (parent or guardian), give the authority to the technical staff (coaches, manager, technical director) to administer first aid and transport my child ________________________________ (name) to the hospital for examination and treatment if necessary. CS Dieppe is not responsible for any accident or injury involving my child.