

**COMETS TRACK AND FIELD CLUB
ATHLETE MEDICAL INFORMATION SHEET
(TO BE COMPLETED ANNUALLY)**

Last Name _____ First Name _____

Date of Birth D/M/Y) _____ BC Athletics # _____ BC Medical# _____

Address _____ Home Phone _____

City _____ Postal Code _____

Mother's Name _____ Father's Name _____

Business telephone _____ Business telephone _____

Person to contact in case of emergency, if parents are not available:

Name _____ Telephone _____

Doctor's Name _____ Telephone _____

Dentist's Name _____ Telephone _____

Please circle the appropriate responses below:

- Yes No Wears glasses
- Yes No Lenses shatterproof
- Yes No Wears contact lenses
- Yes No Wears dental appliance
- Yes No Hearing Problem
- Yes No Asthma
- Yes No Trouble breathing during exercise
- Yes No Fainting episodes during exercise
- Yes No Diabetic
- Yes No Heart Condition
- Yes No Allergies (please specify) _____
- Yes No Epileptic
- Yes No Medication (please specify) _____
- Yes No Wears a medic alert bracelet or necklace
- Yes No Surgery in last year _____
- Yes No Has been in hospital in the last year (specify date) _____
- Yes No Has had injuries requiring medical attention in the past year

Yes No Presently injured

Please give details below if you answered "yes" to any of the above items: _____

(Use a separate sheet if necessary)

Medications_____

Allergies_____

Medical Conditions_____

Recent Injuries_____

Last Tetanus Shot_____

Any information not covered above_____

*** Your physician should check any medical condition or injury problem before you or your child participate in the Comet program.

I understand that it is my responsibility to keep my/or my child's coach advised of any change in the above information as soon as possible. I also understand that in the event of an emergency, in which no one can be contacted, a member of the Comets coaching staff will take me or my child to the hospital (or to a Doctor) as required.

I hereby authorize the attending physician or nursing staff to undertake examination, investigation, and necessary treatment for me or for my child.

I also authorize release of information to appropriate persons(personal coach/physician/meet coach) as deemed necessary.

Signature of Athlete_____ Date_____

Signature of Parent/Guardian(if athlete is less than 19 years of age)
