Saskatchewan Cycling Association
MEDICAL INFORMATION FORM

Event: _____

In order to minimize risk and to provide you with medical care, it is very important that you fill this form out carefully, completely and legibly. If you are uncertain about any question, please consult your family physician.

Name (last) _____ **(first)** _____
Club _____
Phone _____ **Birth Date (DD/MM/YYYY)** _____
Address _____
_____ **Postal Code** _____
Provincial Medical Insurance Number _____
Additional insurance (Blue Cross, GMS)
_____

Next of kin **Name** _____
Relationship _____
Home Phone _____ **Work Phone** _____

Other contact **Name** _____
Relationship _____
Home Phone _____ **Work Phone** _____

Family Physician _____ **Phone** _____
Family Dentist _____ **Phone** _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I authorize emergency medical and/or dental treatment or surgical operation for myself, son or daughter if such treatment is deemed necessary.

Name of athlete or Parent/Guardian _____
Signature of athlete or Parent/Guardian _____ **Date** _____
(If athlete is not of legal age)

Name of Witness (please print) _____
Signature of Witness _____ **Date** _____

You have a right to privacy of any medical information. ALL MEDICAL INFORMATION IS CONFIDENTIAL AND WILL BE VIEWED ONLY BY THE CHAPERONE, COACH (OR THEIR DESIGNATE), AND ATTENDING MEDICAL STAFF.

MEDICAL HISTORY

In the past 12 months -	Yes	No
-Have you had or do you now have high or low blood pressure?		
-Have you had or do you have epilepsy or fits?		
-Have you had a concussion or been "knocked out"?		
-Have you been treated for an infectious disease?		
If yes, which disease		
Have you ever had to stay in hospital overnight?		
If YES, what for?		
Have you ever had surgery?		
If YES, what for?		
Have you ever broken any bones		
If YES, which bones?		
Do you wear contact lenses or glasses?		
Do you have any pins/plates/screws in your body from bone or joint surgery?		
If so, where?		
Do you wear any dental appliances such as braces or a plate?		
Do you have any food or other allergies e.g. (nuts, wasps)?		
If YES, please list.		
Are you taking any prescription or non-prescription medications?		
If YES, please list.		
Do you have any allergies to medications?		
If YES, please list.		

When were your immunizations last updated? (Including tetanus) (month/year) _____/_____

Circle any areas, which you have injured in the past 12 months:

Hand	Elbow	Neck	Hip	Shin/Calf	Wrist	Knee	Foot
Arm	Chest	Thigh	Ankle	Forearm	Shoulder	Back	Head

FAMILY HISTORY

Has any of your family had any of these illnesses? If YES, circle the illness.

Diabetes	Allergies	Arthritis	Neurological Disorders
High Blood Pressure	Heart Disease	Gout	High Cholesterol
Bleeding Problems	Kidney Disease	Mental Illness	Sickle Cell Anemia
Aneurysm			

Do you have any other health concerns that have not been mentioned above?

_____

_____

_____

Forward to:
Sask Cycling Association
2205 Victoria Ave
Regina, Sask S4P 0S4