

MEDICAL INFORMATION FORM (All information will be kept strictly confidential)		
Name:	DOB:	Age:
Address:		
City:	Province:	Postal Code:
Phone: (home)	(work)	(other)
Medical # (PHN):	Doctor:	Phone:
Dental Insurance: Yes No	Dentist:	Phone:
Name of Parents/Guardians:		
Emergency Contact:		Phone:
Wear Contact Lens: Yes No		
Allergies (medications, foods, topical substances):		
Medical Conditions (Epilepsy, Asthma, Diabetes, etc.):		
Prescription Medications (name & dosage):		
Previous Injuries and Dates (concussions, broken bones, knee sprains, neck, etc.):		
Operations? (when & why):		
I certify all above information to be complete and correct.		
Signature (parent or guardian if under 18)		Date