

RINGETTE BC MEDICAL FORM

Ringette Association: _____

MEDICAL INFORMATION FORM (All information will be kept strictly confidential)			
Name:		DOB (MMDDYYYY):	
Address:		City:	Postal Code:
Home Phone:		Cell Phone:	
Medical Insurance Numbers	Provincial:	Other Insurance:	
Subscriber:		Dental Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Parent(s)/Guardian(s):			
Emergency Contact:		Telephone:	
Doctor's Name:			
Doctor's Address:		Doctor's Telephone:	
Allergies (medications, foods, topical substances):			
Medical Conditions (Epilepsy, Asthma, Diabetes, etc.):		Prescription Medications (Name & Dosage):	
Previous Injuries & Dates (Concussions, knee sprains, neck injuries, etc.):		Wear Contact Lenses: <input type="checkbox"/> Yes <input type="checkbox"/> No	
I certify all information above to be complete and correct.			
Parent or Guardian (if under 18):		Date:	
Signature:		Date:	