CAQVC

Central Alberta Queens Volleyball Club 2020

PLAYER MEDICAL FORM

Name: _____ **Date of Birth:** _____
(dd/mm/yyyy)

Person to be contacted in case of emergency (Relationship): _____

Phone Numbers: DAY _____ EVENING _____

Alternative Contact (Relationship): _____

Phone Numbers: DAY _____ EVENING _____

Family Doctor: _____ **Phone Number:** _____

Alberta Health Care Number: _____

Volleyball Alberta Number: _____

Relevant Medical History

Medications: _____

Allergies: _____

Previous Injuries: _____

Does the participant carry and know how to administer their own medications? ☐ **YES** ☐ **NO**

Other Conditions (braces, contact lenses, etc.): _____

_____

_____

_____

_____

_____

Please photocopy *BIRTH CERTIFICATE* on back of form.

PLEASE PRINT & BRING TO FIRST PRACTICE

Note: *Medical Information is confidential. Keep this card with the team at all times. These cards should not be available to anyone other than the authorized individuals.*