

Peterborough Rowing Club - Athlete Medical Information

This form will be provided to medical professionals in the event of an emergency.
Confidentiality will be respected.

ACCURACY IS ESSENTIAL - PLEASE PRINT CLEARLY IN BLOCK LETTERS

Name: _____ Female Male Date of Birth: _____
MONTH DAY YEAR

* Health Card #: _____ (Include letters if a replacement card)

Parent / Guardian: _____

Home Address: _____
STREET ADDRESS CITY/TOWN POSTAL CODE

Home Phone: _____ Other Phone: _____

Emergency Contact Information

Name(s): _____

Primary Phone: _____ Other Phone: _____

Doctor's Contact Information

Doctor's Name: _____ Office Phone: _____

Office Address: _____
STREET ADDRESS CITY/TOWN POSTAL CODE

Medical History

Dietary Info: Vegetarian Vegan Lactose Intolerant Gluten Free Other:

Food allergy or sensitivity: Life Threatening? Yes No

Drug allergy or sensitivity: Life Threatening? Yes No

Other allergies or sensitivities: Life Threatening? Yes No

Asthma:

Diabetes:

Epilepsy / Seizures:

Heart condition:

Back or other joint problems:

Rash/skin conditions:

Recent illness or surgery:

Any other disability/condition:

Any special habits, fears or anxieties:

Date of last tetanus vaccination: _____
MONTH DAY YEAR

Additional Health Information (e.g., current medications):

Please check this box if there is additional information written on the back of this page

Signature: _____ Date: _____