MEDICAL INFORMATION FORM (All information will be kept strictly confidential)			
Name:			Age:
Address:	City:	Province:	Postal Code:
Home Phone #:		Cell Phone #:	
Medical Insurance Numbers	Provincial:	Other Insurance:	
Subscriber:		Dental Insurance: ☐Yes ☐ No	
Name of Parents:			
Emergency Contact:		Telephone #:	
Doctor's Name:			
Address:		Telephone #:	
Wear Contact Lenses: ☐ Yes ☐ No		Allergies (medications, foods, topical substances):	
Medical Conditions (Epilepsy, Asthma, Diabetes, etc.):		Prescription Medications (Name & Dosage):	
Previous Injuries & Dates (Concussions, knee sprains, neck injuries, etc.):		Any Operations? (When & Why):	

I certify all information above to be complete and correct.	
Parent or Guardian (if under 18):	Date:
Signature:	Date:

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