Athlete Medical Information Sheet and Travel Medical Authorization

To whom it may concern,

I / We _____

Full name(s) of parent(s) / person(s) / organization giving consent

Address _____

Street Address, City

_____

Province / State, Country

_____ _____

Telephone Email

Am / are the parent(s), legal guardian(s) or other authorized person(s) or organization with custody rights, access rights or parental authority over the following child:

INFORMATION ABOUT TRAVELLING CHILD

Name: _____

Full name of child

Date and place of birth: _____ _____

dd/mm/yy City, Province / Territory

Child's Provincial / Territorial Health Card #: _____

Issuing Province / Territory of Health Card #: _____

Child's Supplemental Health Insurance Policy #: _____

Provider of Supplemental Health Insurance: _____

Family Doctor: _____

Name of Doctor

_____ _____

Street Address, City Telephone

Questions regarding information in this Athlete Medical Information Sheet and Travel Medical Authorization should be directed to the person(s) or organization giving consent.

EMERGENCY CONTACTS

	Emergency Contact #1	Emergency Contact #2
Name (first & last)		
Relationship		
Address: (street, city, country, postal code)		
Telephone #		
Cell phone #		
E-mail Address		

_____
Initials

Healthcare Directive: For the duration of the trip listed below, in the event that I am unable to make healthcare decisions for my child / ward, and my secondary emergency contacts (listed above) are unavailable, I authorize the below named parties to make healthcare decisions for my child / ward on my behalf.

Travel Information: _____ _____

Date of Departure to Date of Return Travel Location(s)

INFORMATION ABOUT ACCOMPANYING PERSON

Name: _____
Full name(s) of accompanying person(s)

_____
Full name(s) of accompanying person(s)

_____
Full name(s) of accompanying person(s)

Relationship to Child: _____
Mother, father, grandparent, sibling, relative, friend, coach, other

MEDICAL CONDITIONS, ALLERGIES and INJURY HISTORY

In accordance with the Province of Manitoba's Personal Health Information Act (PHIA) and accompanying Personal Health Information ACT (PHIA) Regulations all personal health information provided on this form will be kept confidential unless required in the provision of medical or other care for the party in question.

Medications and Medical Conditions

Medical conditions:

_____

Name of medication: *How often taken:* *For what condition?*

_____

_____

_____

Allergies (Medication, Environmental, Food, etc.)

Allergy: *Reaction:* *Treatment, if exposed:*

_____

_____

_____

NOTE: If your child has any dietary restrictions, sensitivities or allergies relevant to their participation in the trip / tournament, we strongly recommend that you discuss them with the Coach and Travel Coordinator prior to departure (this is particularly relevant on trips where catered meals are being arranged).

Injury History

_____

_____

Injury: *Symptoms:* *Treatment, if aggrevated:*

_____

_____

_____

This letter must be signed before a witness who has attained the age of majority (18 or 19, depending on the province or territory of residence) OR certified by an official who has the authority to administer an oath or solemn declaration.

SIGNATURE OF PERSON(S) GIVING CONSENT	SIGNATURE OF WITNESS	or OFFICIAL SIGNATURE
_____	_____	_____
Fullname of party giving consent	Fullname of witness	
_____	_____	Signed before me this _____
Signature party giving consent	Signature of witness	day of _____ _____ (month / year)
		_____ Signature of Official
		_____ Name/Title of Official

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