ATHLETE MEDICAL INFORMATION FORM

Athlete's Full Name:								
Birth Date (dd/mm/yy)		**Age**		**Male**	☐	**Female**	☐	**Non-binary** ☐
Address	Street							
	City		Province			Postal Code		
Athlete's Email:								
Athlete's Phone Number:								
Healthcare Number:								

Family Doctor:	Name	Phone #	**Family Dentist:**	Name	Phone#

Emergency Contacts (please provide two) (***NOTE: first contact listed will be first to call unless otherwise specified***)			
CONTACT #1 Name:		**Relationship:**	
Cell Phone:		**Home Phone:**	
CONTACT #2 Name:		**Relationship:**	
Cell Phone:		**Home Phone:**	

HEALTH HISTORY		DETAILS/MEDICATIONS
Allergies	**Yes** ☐ **No** ☐	
Asthma (Respiratory)	**Yes** ☐ **No** ☐	
Trouble breathing during exercise	**Yes** ☐ **No** ☐	
Blackouts/Fainting	**Yes** ☐ **No** ☐	
Chest pain	**Yes** ☐ **No** ☐	
Diabetes – Type I ____ Type 2 ____	**Yes** ☐ **No** ☐	
Seizures/Epilepsy	**Yes** ☐ **No** ☐	
Hearing Disorder	**Yes** ☐ **No** ☐	
Heart Condition	**Yes** ☐ **No** ☐	
Recurring Headaches	**Yes** ☐ **No** ☐	
Seizures	**Yes** ☐ **No** ☐	
Wears Glasses	**Yes** ☐ **No** ☐	
Contact Lenses	**Yes** ☐ **No** ☐	
Previous Major Injuries	**Yes** ☐ **No** ☐	Specify:

HEALTH HISTORY		DETAILS/MEDICATIONS
Presently injured. Body part__________	Yes ☐ No ☐	
Concussion	Yes ☐ No ☐	
Fracture or Dislocation	Yes ☐ No ☐	
Wears a medical information necklace/bracelet	Yes ☐ No ☐	Purpose:
Wears a dental appliance	Yes ☐ No ☐	Specify:
Medications	Yes ☐ No ☐	Specify:
Other:	Yes ☐ No ☐	

Any other medical information not mentioned above	

I understand that it is my responsibility to keep the coaching staff advised of any changes in the above information as soon as possible. I hereby consent to health care providers to administer any necessary medical care as a result of illness/injury. This consent includes First Aid and transportation to/from health care providers.

To the best of my knowledge, all information contained in this sheet is correct.

Consent to Disclose Personal Health Information

I consent to the collection, use and disclosure of the personal information contained in this Athlete Medical Information Form (the "Information") and acknowledge that it is properly collected by the Abbotsford Minor Fastball Association ("AMFA") in accordance with the *Personal Information Protection Act*, SBC 2003, c.63 ("PIPA").

I understand that the Information will be protected by my Athlete's coaches and team staff, and that the Information may be disclosed to those providing medical assistance to the Athlete, including doctors, nurses, paramedics, and other first responders, in the discretion of my Athlete's coaches and team staff.

I understand that the AMFA must protect personal information in its custody or under its control by making reasonable security arrangements to prevent unauthorized access, collection, use and disclosure, modification or disposal or similar risks. I agree that the maintenance of the Information in my Athlete's Coaches custody is reasonable security.

I understand that If the AMFA uses the Information to make a decision that directly affects the Athlete or the AMFA, the AMFA will retain that information for at least one year after using it so that the Athlete has a reasonable opportunity to obtain access to it. The AMFA will destroy its documents containing the Information as soon as it is reasonable to assume that the purpose for which that personal information was collected is no longer being served by retention of the personal information, and retention is no longer necessary for legal or business purposes.

I specifically release, remise and forever quit claim the AMFA, its coaches, staff, volunteers and executive, from any liability in connection with the provision of medical assistance based on the Information and consent provided herein.

I understand that I have the ability to refuse or revoke consent on behalf of the Athlete at any time and further understand that revocation or refusal of consent may negatively impact the health and well-being of the Athlete.

(If under 18 please have parent or legal guardian sign)

Name		**Signature**		**Date (dd/mm/yy)**	