



Minnow Lake Place Taekwondo
1127 Bancroft Drive
Sudbury, Ontario
P3B 1R6

MEDICAL INFORMATION
 PLEASE PRINT CLEARLY

Athlete Name:				
Birth Date:	(dd/mm/yy)	Age:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Address				
Street				
City		Province	Postal	
Medicare Number:				

Parents Name:				
Address				
Street				
City		Province	Postal	
Home #:		Work #:	Cell #:	

Family Doctor	
Name	Phone #:

Heath History:

Details:

- | | | | |
|----------------------------------|------------------------------|-----------------------------|-------|
| Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Asthma (Respiratory) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Blackouts/Fainting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Chest pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Hearing Disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Heart Condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Recurring Headaches | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Seizures | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Glasses | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Contact Lenses | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Injuries (specify) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Medications (specify) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Concussions | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Other (including recent surgery) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Other: | | | _____ |

Member in good standing:

