

# Guelph Rowing Club – Athlete Medical Information

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

*FULL DISCLOSURE IS ESSENTIAL- PLEASE PRINT CLEARLY*

Athlete Name: \_\_\_\_\_ Date of Birth: MM/DD/YY  Women's Team  
 Men's Team

**Health Card #** \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street Address City Postal Code

Parent Phone: \_\_\_\_\_ Parent Email: \_\_\_\_\_

Athlete Phone: \_\_\_\_\_ Athlete Email: \_\_\_\_\_

## Emergency Contact Information

Name(s): \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

## Doctor's Contact Information

Doctor's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_  
Street Address City Postal Code

## Medical History

Dietary Info:  Vegetarian  Vegan  Lactose Intolerant  Gluten Free  Other: \_\_\_\_\_

Food Allergy/Sensitivity \_\_\_\_\_ Life Threatening  Yes  No

Drug Allergy/Sensitivity \_\_\_\_\_ Life Threatening  Yes  No

Other Allergies/Sensitivities \_\_\_\_\_ Life Threatening  Yes  No

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Epilepsy/Seizures \_\_\_\_\_

Heart/Vascular Conditions \_\_\_\_\_

Back or Joint Problems \_\_\_\_\_

Skin Problems \_\_\_\_\_

Recent Illness or surgery \_\_\_\_\_

Other medical conditions \_\_\_\_\_

Any fears, anxieties, special habits \_\_\_\_\_

Date of last tetanus vaccination: MM/DD/YY

**Additional Health Information (including current medications):**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_