Medical History Document (form SF-5)

MEDICAL HISTORY DOCUMENT				
Medications				
Allergies				
Previous Injuries				
Do you carry and know how to administer your own medication(s)?	Yes	☐	No	☐
Any other conditions (contact lenses):				
Doctor's Name and Phone Number:				
Dentist's Name and Phone Number:				
I understand that, in the event that no one can be contacted, the Curling club staff or volunteers will admit my child to the hospital if deemed necessary. I also understand, that under no circumstances is the Curling Club or its staff or volunteers, liable or responsible for the treatment of said injured or ill player. I hereby authorize the physician and nursing staff on duty at any emergency unit to undertake examination, investigation and necessary treatment of my child.				
Parent or guardian's signature				
Print Name				
Date				