**Medical History Document (form SF-5)**

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| **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 |  |