Special Olympics Newfoundland & Labrador
*CLUB*_____
Medical Emergency Information

Athlete's Full Name: _____

Gender: M F (Circle) **Date of Birth:** _____/_____/_____ Day Month Year

MCP Number: _____ **Expiry Date:** _____

Doctor's Name: _____ **Phone Number:** _____

Emergency Contact #1: _____ **Phone Number: (H)** _____

Relation to Athlete: _____ **(Cell)** _____

Emergency Contact #2: _____ **Phone Number: (H)** _____

Relation to Athlete: _____ **(Cell)** _____

Medical History: (Circle: Yes or No)

Asthma	Y	N	If Yes, use of inhaler	Y	N
Down Syndrome	Y	N	If Yes, Atlanto-Axial x-ray: Y N Date: _____ Pos. Neg.		
Cerebral palsy	Y	N			
Diabetic:	Y	N	If yes, treatment: Diet Pills Injection		
Heart disease	Y	N	If yes, specify: _____		
Major surgery	Y	N	If yes, specify: _____		
Seizures	Y	N	If yes, Type _____ How are they Controlled? _____		
Tetanus shot	Y	N	Within: (✓) 5 Years ____ 10 years ____		

Any Reactions and/or Special Care:

_____

Use of the following: (✓)

Glasses _____ Dentures _____
Hearing Aid _____ Contact Lenses _____

Other(s): _____

Medications (if more space is required, please attach an additional sheet):

Medication and Dosage: _____Times: _____Self Administered: Y N

Medication and Dosage: _____Times: _____ Self Administered: Y N

Allergies (Medication, Food, Stings/Bites, etc.):

_____

Other(s): _____

Symptoms, treatment: _____

Special diet requirements: _____

Please indicate any behavioral problems this athlete might exhibit as well as describe effective strategies to deal with the behavior. Please elaborate on a separate sheet where needed.

Does the Athlete require the assistance of a respite worker. Yes _____ No _____

One copy of this form should be kept on file with the Regional Coordinator, and another with the head coach of any program in which the athlete is participating. Please inform the coaches and Regional Coordinator of all changes in the athlete's medical condition or treatment as they occur. Please ensure an updated medical form accompanies the athlete each time they travel to a competition, and that coaches are made aware of all pertinent medical facts both current and past..

Consent for medical treatment: Yes _____ No _____

Name of Person completing this form: _____ Signature: _____

Date: _____