Appendix 10 - Athlete Medical Data Record

Complete this form for each of your athletes.

NOTE: IF THE REQUESTED INFORMATION IS NOT PROVIDED, THE ATHLETE WILL NOT BE PERMITTED TO PARTICIPATE IN THE ACTIVITY.

PLEASE PRINT CLEARLY IN INK OR TYPE

<table>
<tr><td colspan="3">NAME OF PARTICIANT</td><td>DATE OF BIRTH (D/M/Y)</td></tr>
<tr><td colspan="4">ADDRESS:</td></tr>
<tr><td>CITY</td><td>PROVINCE</td><td>POSTAL CODE</td><td>TELEPHONE NO.</td></tr>
<tr><td colspan="2">NAME OF PARENT/GUARDIAN (IF < 18 YEARS OLD.)</td><td>RELATIONSHIP</td><td>TELEPHONE NO.</td></tr>
<tr><td colspan="4">PLEASE LIST ALL EXISTING MEDICAL CONDITIONS/ALLERGIES (INCLUDING FOOD) OF THE PARTICIPANT</td></tr>
<tr><td colspan="4">PLEASE LIST ANY MEDICATIONS REQUIRED (TYPES/TIMES REQUIRED/STORAGE REQUIREMENTS/ADMINISTRATION PROCEDURES)</td></tr>
<tr><td>HEALTH CARD NUMBER (INCL. VERSION CODE)</td><td>NAME OF FAMILY PHYSICIAN</td><td colspan="2">TELEPHONE # OF PHYSICIAN</td></tr>
<tr><td colspan="4">I hereby give permission for emergency medical treatment to be administered to my son/daughter, as may be determined in the reasonable discretion of his/her personal coach or program supervisor. It is understood that whenever reasonably possible, relatives will be contacted and informed of the problem, diagnosis, treatment required and anticipated medical results.

I understand that it is my responsibility to ensure that the information on this form is kept current and I will notify the coach of any changes immediately.</td></tr>
<tr><td colspan="3">SIGNATURE OF PARTICIPANT (OR PARENT/GUARDIAN IF PARTICIPANT IS UNDER THE AGE OF 18)</td><td>DATE (D/M/Y)</td></tr>
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