THE MANITOBA CYCLING ASSOCIATION

309 – 200 Main Street
Winnipeg, MB R3C 4M2

Date:_____

MEDICAL INFO & EMERGENCY CONTACT FORM

Athlete's Name: _____ **Address:** _____

Home Phone #: _____ **City:** _____ **Prov:** _____

Alternate Phone #:_____ **Manitoba Health: Reg #** _____

Birth Date: _____ **Personal ID #**_____

Medications:_____ **Allergies** _____

_____ _____

_____ _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Parent's Name: _____

Work Phone #: _____ **City:** _____

Home Phone #: _____ **Prov:** _____

Cell Phone #: _____ **Email:** _____

Alternate Name #1 _____ **City:** _____

Work Phone #: _____ **Prov:** _____

Home Phone #: _____

Cell Phone #: _____

Alternate Name #2 _____ **City:** _____

Work Phone #: _____ **Prov:** _____

Home Phone #: _____

Cell Phone #: _____

- **If you are taking any medications please have your Physician fill out the attached form**
- **Be sure to fill out all forms completely**

Signed this _____day of_____,200___. Athlete:_____

Signed this ___day of_____,200__. Parent or Legal Guardian: _____

PHYSICIAN'S INSTRUCTIONS

Diagnosis _____

Name of medication(s) / procedure(s) _____

_____

Date Prescribed _____ Dosage to be given _____

Times to be administered OR Describe situations for treatment/intervention _____

_____

_____

_____

Possible side effects (Describe in lay terms) _____

_____

NOT to be administered if… (Describe situation) _____

_____

Action to be taken if side effects or emergency occurs _____

_____

Storage instructions _____

Equipment or supplies to be used _____

Comments _____

_____

_____

Physician Name (print) _____ Physician Ph. # _____

Physician Signature _____ Date _____

Reviewed _____ _____

Athlete Signature **Date**

Reviewed _____ _____

Parent/Guardian Signature **Date**