



Gymnastics Nova Scotia

Record Of Medical Information

Athlete Name: _____
Address: _____ Emerg Contact: _____
City/Prov: _____ Relationship: _____
Postal Code: _____ Emergency Ph: _____
Phone #: _____
Birthdate: D _____ M _____ Y _____

Provincial Plan # & Expiry Date (MSI for NS): _____

Medical Information:

Please indicate any medical information, allergies or conditions that may be important in an emergency

In the event of medical treatment parents and or gaurdians will be contacted at the emergency number noted above.

RECORD OF MEDICAL CONSENT FOR MINORS

In the event of an emergency I, hereby give permission for my son / daughter to receive emergency medical / surgical care administered by qualified staff and / or Physicians.

Date: _____

PARENT / GUARDIAN

WITNESS

Name: _____

Name: _____

Signature: _____

Signature: _____

Relationship: _____

Relationship: _____