

**EAST YORK CURLING CLUB  
LITTLE ROCKS MEDICAL DATA FORM**

**Please complete and return to the EYCC Little Rocks Section. (Please Print)**

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent or Guardian's Name: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Card No: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If parents are unavailable, person to contact in case of an emergency:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone No: \_\_\_\_\_

List any known medical problems or medications taken on a regular basis that should be known to your coordinator (please include food allergies):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that, in the event that no one can be contacted, the East York Curling Club staff or volunteers will admit my child to hospital if deemed necessary. I also understand, that under no circumstances is the East York 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.

**Signature of Parent/Guardian:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_