ODMLA (Northmen) Participant Medical Information Card

Name: _____

Date of Birth: _____ /_____ /_____

Day Month Year

Person to be contacted in case of emergency:

_____

Phone numbers: Day_____ Evening_____

Alternative Contact:_____

Phone numbers: Day_____ Evening_____

Family Doctor Name: _____

Family Doctor Phone Number: _____

Medical Insurance Number (OHIP etc)_____

Relevant Medical History

Medications: _____

Allergies: _____

Previous Injuries: _____

Other Conditions: _____

Braces, Contact Lenses, Glasses etc: _____

Does participant carry and know how to administer his or her own medications?

Yes: _____No_____

Note: All information is confidential. Keep this card with the team at all times... These cards will only be available to authorized individuals.