MEDICAL TREATMENT CONSENT
(FOR ALL PARTICIPANTS)

I,_____(*name of participant if over 18 years, or parent/guardian if participant is under 18 years*), on behalf of_____(*name of child/ward*), give permission to the officials and coaches of the Volleyball Alberta (VA) to make decisions concerning my child's/ward's medical care and treatment, and where necessary to authorize such care and treatment.

I understand that the officials and coaches of the Volleyball Alberta will make every reasonable effort, in the circumstances, to speak to the below Emergency Contact(s) regarding my or my child's/ward's medical status in the event medical care or treatment is required. In the event that the Emergency Contact(s) cannot be reached, I hereby give my permission to the licensed physician, dentist, athletic therapist, nurse or other medical professional whose services might be required to provide medical care and treatment to my child/ward.

By signing below, I indicate that I have the understanding and capacity to communicate health care directives for my child/ward and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the officials and coaches of Volleyball Alberta.

I, the parent/guardian, agree that I have reviewed the Consent for Medical Treatment and my signature affixed indicates my agreement with such consent for medical treatment.

I have read and agree to be bound by the Consent for Medical Treatment.

_____	_____	_____
Print Name of Parent/Guardian	Signature of Parent/Guardian	Date

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MEDICAL TREATMENT INFORMATION
(FOR ALL PARTICIPANTS)

Athlete Name: _____ Age: ____

Birth Date (DD/MM/YY): _____ Height: ____ Weight: ____

Mailing Address: _____

City_____ Province: _____ Postal Code: _____

Athlete Home Phone Number: _____

Athlete Cell Number: _____

Athlete Email Address: _____

Alberta Health Card Number **(athlete needs to carry card during training/competition):**
_____ **(Optional)**

Family Physician: _____ Contact #:_____

EMERGENCY CONTACT INFORMATION

	Primary Contact	Secondary Contact	Tertiary Contact
Name:			
Relationship to Athlete:			
Home Phone			
Work Phone:			
Cell Phone:			

MEDICATIONS

	Medication	Medication	Medication
Name:			
Dosage:			
Frequency Taken:			
Condition Prescribed For:			

Athlete Name: _____

ALLERGIES: _____

_____

KNOWN MEDICAL CONDITIONS: _____

_____

_____

RECENT INJURIES/ILLNESSES: _____

_____

_____

HAVE YOU BEEN KNOCKED UNCONSCIOUS OR HAD A CONCUSSION? IF SO, WHEN?

_____

_____

_____

DO YOU KNOW OF ANY REASON WHY YOU SHOULD NOT DO PHYSICAL ACTIVITY?

_____