CHELSEA NORDIQ
MEDICAL INFORMATION AND AUTHORIZATION
FOR 201_ - 201_ SEASON

MEMBER INFORMATION	DATE OF BIRTH	D		M		Y	

NAME:	
ADDRESS:	

POSTAL CODE:		TELEPHONE 1:	
TELEPHONE 2:		E Mail	

PROVINCIAL MEDICAL #	
PRIVATE INSURANCE (COMPANY AND #)	
MEDICAL INFORMATION	

HEIGHT:		WEIGHT:	
BLOOD TYPE:			
ALLERGIES:			
MEDICATIONS:			
PREVIOUS MEDICAL HISTORY / KNOWN CONDITIONS:			

AUTHORIZATION TO SEEK TREATMENT	

I, the undersigned, authorize the Chelsea Nordiq Team Coach or chaperone, in the event of accident or illness, to authorize on my behalf all procedures, including admission to hospital and necessary treatment therein, as may be deemed essential for my well-being. It is understood that every effort will be made to contact my next of kin (listed below) as soon as possible.

SIGNATURE:		DATE:	
NEXT OF KIN INFORMATION			
NAME:			

RELATIONSHIP TO MEMBER:	
ADDRESS (IF DIFFERENT FROM ABOVE)	

PROVINCE:		POSTAL CODE:	
TELEPHONE 1:		TELEPHONE 2:	