

RECREATION & SPECIAL NEEDS PARTICIPANT CONSENT AND MEDICAL DATA RECORD

NOTE: IF THE REQUESTED INFORMATION IS NOT PROVIDED, THE APPLICANT WILL NOT BE PERMITTED TO PARTICIPATE IN THE ACTIVITY

PLEASE PRINT CLEARLY IN INK OR TYPE

NAME OF PARTICIPANT			BIRTH DATE (D/M/Y)		
NAME OF CLUB		G.O. MEMBER #		DISCIPLINE	
ADDRESS					
CITY		PROV	POSTAL CODE		TELEPHONE NO.
NAME OF PARENT/GUARDIAN (if under 18)			RELATIONSHIP		TELEPHONE NO.
DOES THE PARTICIPANT HAVE ANY PHYSICAL, MENTAL, OR MEDICAL CONDITIONS THAT, FOR SAFETY REASONS, SHOULD BE DISCLOSED? ___		YES <input type="checkbox"/>	IF YES, COMPLETE FORMS A, B & C	NO <input type="checkbox"/>	IF NO, THEN COMPLETE FORM A ONLY
HAS THE PARTICIPANT EVER HAD AN INJURY OR ACCIDENT REQUIRING ONGOING MEDICAL ATTENTION? NO _____ YES _____		SPECIFY			
HAS THE PARTICIPANT EVER HAD SURGERY?		YES <input type="checkbox"/>	IF YES, COMPLETE FORMS A, B & C	NO <input type="checkbox"/>	IF NO, THEN COMPLETE FORM A ONLY
NAME OF FAMILY PHYSICIAN		TELEPHONE # OF PHYSICIAN			FAX # OF PHYSICIAN

PARENT/GUARDIAN CONSENT OF PARTICIPATION AND WAIVER

By submitting and signing this form, I acknowledge that I am aware that there are risks associated with gymnastics. I warrant that the participant named on this information form, is physically fit to participate in gymnastics. I declare that I have accurately disclosed all information regarding physical, mental or medical conditions affecting the named participant and acknowledge that this information may be used for the Club/G.O=s use in the delivery of a gymnastic program. I acknowledge that there is potential risk for injury involved in training and competing in any sport. I understand that Gymnastics Ontario has tried to create a safe and controlled environment for participation and that the Club has established rules for participation on and about the gymnastic area that must be followed by the participant. I understand that failure to comply with any of the policies and rules of the Club and/or Gymnastics Ontario may result in the suspension or termination of membership. I waive the rights of the participant to damages or other costs in the event injury is caused due to participation in gymnastics or other involvement with the Federation.

I hereby give permission for emergency medical treatment to be administered to my son/daughter, as may be determined in the reasonable discretion of the Meet Director/Team Manager. It is understood that whenever reasonably possible, relatives will be contacted and informed of the problem, diagnosis, treatment required and anticipated medical results.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ENSURE THAT THE INFORMATION ON THIS FORM IS KEPT CURRENT AND I WILL NOTIFY THE CLUB OF ANY CHANGES IMMEDIATELY

SIGNATURE OF PARTICIPANT (OR PARENT/GUARDIAN IF PARTICIPANT IS UNDER 18 YEARS OF AGE)	DATE (D/M/Y)
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FOR CLUB USE

(Over)

EMERGENCY CONTACT INFORMATION

IN THE CASE OF AN EMERGENCY INVOLVING THE <u>PARTICIPANT</u> , PLEASE CONTACT ONE OF THE FOLLOWING INDIVIDUALS		
1.	NAME	HOME TELEPHONE NO.
	RELATIONSHIP	BUSINESS TELEPHONE NO.
	ADDRESS	
2.	NAME	HOME TELEPHONE NO.
	RELATIONSHIP	BUSINESS TELEPHONE NO.
	ADDRESS	
3.	NAME	HOME TELEPHONE NO.
	RELATIONSHIP	BUSINESS TELEPHONE NO.
	ADDRESS	