

**THE ROYAL CANADIAN LEGION
TRACK AND FIELD PROGRAM
PARENTAL-GUARDIAN CONSENT/PERSONAL HEALTH RECORD FORM**

SELECT ONE OR BOTH “” BY INDICATING WITH A “✓”

District Provincial National

(PLEASE PRINT)

NAME OF ATHLETE: _____

ADDRESS: _____

CITY: _____ **PROV:** _____ **POSTAL**
CODE: _____

PHONE:(____) _____ **DATE OF BIRTH:** Day _____ Month _____ Year _____

E-MAIL ADDRESS _____

PROVINCIAL HEALTH CARD No./EXPIRY DATE: _____

DATE OF LAST COMPLETE MEDICAL CHECKUP _____

If not available at the above address and phone number during the event(s), please provide the address and phone number where a parent or legal guardian may be reached.

PARENT OR LEGAL GUARDIAN:

ADDRESS: _____

PHONE:(____) _____

The parent or legal guardian is assuming full responsibility for the applicant's health being such that athletic activities will in no way aggravate any conditions present. It is assumed that the parent will know their child's condition or seek competent advice before completing the form. If for any reason the athlete's medical status changes after this form has been signed and your consent should be withdrawn or changed, the parent/guardian is obligated to notify their Royal Canadian Legion Provincial Command (905-841-7999), or Dominion Command in Ottawa at (613) 591-3335.

List any illness or disability, including allergies, which might affect the applicant's ability to perform at this event.

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Clearly indicate all medication that the applicant must use during the event period. These must be clearly marked and handed to the nurse upon arrival. **(Name of medication, condition for which it is prescribed, and dosage).**

I hereby, for myself, my heirs, executors and administrators, release and forever discharge The Royal Canadian Legion, its agents, servants, representatives, successors and assignee and other bodies, corporate firms associations or persons connected with the competitors of any and from any and all rights, claims, demands and actions whatsoever that I may have for any and all loss, damage to my equipment or injury sustained by me during the said competition. I also give consent for the free use of my name and/or picture in any broadcast, telecast or other account of the above event. I attest and verify that I am physically fit. I further provide my consent for the provision of emergency medical treatment, if necessary.

SIGNATURE OF ATHLETE: _____

DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____

**THE ROYAL CANADIAN LEGION
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TREATMENT WAIVER FORM**

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District **Provincial** **National**

A variety of therapeutic services may be provided for the athletes attending a Legion Provincial and/or National Track and Field Competition. The therapists may be student therapists that are completing clinical hours as part of their educational program. The athletes may wish to receive treatment before their events to limber up their muscles or following their event to cool down and prevent lactic acid build up in their limbs. The student therapists will be supervised by registered therapists at all times and the treatment will be performed through clothing or directly on skin on areas already exposed (i.e. legs, arms, etc).

ALL athletes under the age of 18, must have a parent or legal guardian sign the consent form before any of the therapeutic services are performed.

In order for an athlete to be eligible for these services, the following form must be completed, signed and provided to the Legion Provincial Command which the athlete is representing:

First/Family Name of Athlete: _____

Phone Number:(____)_____

Do you have any condition(s) that we should be aware of, e.g., diabetes, cancer, phlebitis or high blood pressure? YES NO

Are you taking any medication? YES NO

If yes, please inform your student therapist and/or supervisor as certain conditions may make it inadvisable to receive certain types of treatment.

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Please indicate on the list below, which forms of treatment you will/will not allow your child to undergo:

WILL ALLOW (✓)

WILL NOT ALLOW (✓)

First Aid Treatment

Cryotherapy (ice)

Heat Therapy

Massage Therapy

Physiotherapy

Athletic Injury Taping

Acupuncture

Signature of Parent/Guardian: _____ **Date:** _____

(I give my consent for my child to be treated by a student therapist)

Signature of Athlete: _____ **Date:** _____

(I consent to having a student therapist provide treatment)

**PLEASE BRING A COPY OF THE COMPLETED FORMS
TO THE TREATMENT AREA AND GIVE TO
THE SUPERVISOR IN CHARGE**