

Vision:

Alpine Canada Alpin **Medical Evaluation**

*Please attach a passport style photo with the completed form.

1. ATHLETE PERSONAL INFORM	Date of Birth (DD/MM/YYYY):	Sex: M F
Surname, First Name		
Provincial Health Care Number:		
Additional health care coverage you car	rry, if any;	
Club Name:		
Provincial Ski Organisation:		
2. MEDICAL HISTORY (Attach addi Family History:	itional pages if required)	
Past medical/surgical history (include c	dates of surgeries and physicians name):	
Immunizations (DPT/TD, Hep A and B, F	Flu):	
3. PRESENT MEDICAL STATUS (A Physical Examination:	Attach additional pages if required)	
Biomechanical Examination (includes, r	musculoskeletal exam, joint ROM, alignment):	
Gender/Reproductive Health:	Healthy Male:	Healthy Female:

Note, it is recommended that athletes seek to have a sport vision assessment



4. SUMMARY OF MEDICAL CONCERNS AND ACTION PLAN (Attach additional pages if required)

I hereby certify that this athlete is physically able to participate in all aspects of alpine and/or ski cross racing.

Physicians Signature

Physicians Name (please print)

PLEASE ATTACH ANY ADDITIONAL INFORMATION

** If you are injured throughout the season please inquire with your coach in relation to the FIS single penalty application process.

Telephone

Date