



National Team Program

Water Polo Canada

PERSONAL INFORMATION

Name _____

Address _____

_____ Street City Postal Code

Home # _____ Business # _____ Cell # _____

E-Mail Address _____ Age _____ Birthday _____

MEDICAL HISTORY

Name of person to contact in an emergency _____

Person's Phone # _____ Person's Cell # _____

2nd Person to contact in an emergency _____

Person's Phone # _____ Person's Cell # _____

Medical Card # _____ Province Registered _____

Family Doctor _____ Phone # _____

Medications – Please Describe

Asthma - Please Describe:

Tendonitis or other chronic conditions - Please Describe Condition & Treatments:

Allergies - Please Describe:

Previous Injuries – Please Describe:

PLEASE NOTE: ALL Information is confidential.



Water Polo Canada

Unit 12-1010 Polytek Court, Gloucester, On, K1J 9H9
613-748-5682(ph) /// 613-748-5777(fax)
office@waterpolo.ca

We _____ & _____

give permission for our son / daughter _____ to participate

with the National Team Program.

Signed: _____
Mother/Guardian Date

And/or

Father/Guardian Date