



PATIENT REGISTRATION & CONSENT FORM

GSSMC Satellite Clinic – Vimy Ridge Academy

Personal Contact Information

Name: _____ **PHN:** _____ - _____
Surname Given Name Middle Personal Health Number

Address: _____ **City:** _____ **Prov:** _____

Postal Code: _____ **email address:** _____

Phone: () _____ - _____ home () _____ - _____ work () _____ - _____ cell

Date of Birth: _____ / _____ / _____ **Age:** _____ **Gender:** M F
Year Mon Day

Vimy Ridge Academy Program: _____ **Grade & Program Year:** _____

Parent/Guardian Contact Information

Parent/Guardian: _____ **Phone:** _____ - _____
Name Relation

Family Physician: _____ **Phone:** _____ - _____

Patient and Family Information and Consent Form:

Sport and Exercise Medicine services are available to Student Athletes enrolled in the Vimy Ridge Academy sport programs. Services are being provided onsite at the school by Dr. Erika Persson, FRCPC Dip Sport Med. Students can schedule appointments by self-booking as directed by their parent/guardian, coach or teacher via a sign up sheet in the school office. Clinics will be held weekly, on Tuesdays at the school during the school academic year. Parent(s)/guardian(s) may attend the visits if possible and any investigations that are required such as blood work or diagnostic imaging will be completed outside of the school building at the appropriate facility as directed by Dr. Persson. If a parent/guardian is not present at the onsite school visit, telephone communication with the parent(s)/guardian(s) can be provided, upon request. Follow up appointments will be completed at the school or at the Glen Sather Sport Medicine Clinic (Edmonton Clinic 11400 University Ave) as directed by Dr. Persson. Physical therapy, if suggested, will be the responsibility of the parent(s)/guardian(s) to arrange.

Please be advised the registration information collected will be used for creating a patient file. The information is being collected under the authority of sections 20(b) and 21(1) the *Health Information Act*. The provisions of the *Health Information Act* protect your privacy and the confidentiality of your health information. The *Health Information Act* provides for sharing of patient information between healthcare providers when said sharing contributes to the continuing care and treatment of the patient.

Please be advised the Clinic may need to contact you with regards to your child's care. We may need to leave messages for you and ask that the phone number you provide to us may be used for this purpose.

If you have any questions about the appointments or your child's treatment plan, or the collection and use of their personal/health information, please contact Dr. Erika Persson at the Glen Sather Sport Medicine Clinic at 780-407-5160. Your signature below indicates you understand and comply with the above statements and consent for your child to have Sport and Exercise Medicine services provided to them at the GSSMC Satellite Clinic at Vimy Ridge Academy.

Parent/Guardian Signature: _____ Print Name: _____ Date: ____/____/____
Year Mon Day