

M E D I C A L F O R M

Full Name:

Sex: Male Female Other Date of Birth:

DD/MM/YY

Address:

Street Address

Town

Province

Postal Code

Provincial Health Care Number:

Additional Policies:

Emergency Contacts:

1.

Name

Phone 1

Relationship

Phone 2

2.

Name

Phone 1

Relationship

Phone 2

Medical Information:

Do you have any **physical limitations or medical conditions** that might prevent you from participating in activities requiring sustained physical effort, sitting/walking/hiking on uneven surfaces, or sitting in a kayak for any length of time?

Yes No

If **yes**, please explain:

Do you have any history of the following:

Allergy

Asthma

Joint Problems

Epilepsy

Heart Conditions

Diabetes

Hypoglycemia

Dislocations

Do you have any other conditions? Yes No

If YES to 'OTHER' OR 'ALLERGY' please detail, including food allergies:

Condition / Allergy

Last Incident:

Reaction:

Other helpful information:

Note: If more than one allergy or condition, or more room is needed, please use the form on the following page.

Do you take any medications?

Yes No

Please specify:

Time taken:

Morning

Mid-day

Evening

Effect and Side Effects of medication:

Other Conditions / Allergies

Condition / Allergy

Last Incident:

Reaction:

Other helpful information:

Condition / Allergy

Last Incident:

Reaction:

Other helpful information:

Condition / Allergy

Last Incident:

Reaction:

Other helpful information:

Condition / Allergy

Last Incident:

Reaction:

Other helpful information: