



STRATHCONA PARK LODGE MEDICAL FORM

The purpose of this form is to help our instructors provide the best care for you or your child. Information on this form is considered confidential and will only be shared with medical personnel in the event of an emergency.

This information will not be used to deny you or your child access to the program.

PARTICIPANT INFORMATION

Participant's Name: _____ School/Program: _____

Address: _____ Program Date: _____
Street City/Town Province/State

Phone: _____ Date of Birth (d/m/y): ____/____/____ Age: ____ Gender: M ____ F ____

Doctor's Name: _____ Doctor's Phone Number (____) _____

BC Care Card Number (for BC residents only): _____

Other Health / Medical Insurance (for non-BC residents) Provider: _____ Number: _____

MEDICAL HISTORY

1. Please list any DIETARY RESTRICTIONS: _____

2. Please indicate known ALLERGIES to foods, medications, insect bites and others:

Allergen/Trigger	Reaction (If anaphylactic, participant must bring 2 EpiPens)	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Date of last TETANUS IMMUNIZATION OR BOOSTER (Year) _____ (Children in BC receive tetanus boosters in Kindergarten and grade 9. Adults are recommended to have a booster every ten years.)

4. Are you taking any PRESCRIPTION OR NON-PRESCRIPTION DRUGS currently or while at Strathcona? Yes No

Drug Name	Reason
_____	_____
_____	_____
_____	_____

5. Please indicate if you experience any of the following CHRONIC CONDITIONS:

- | | | | | |
|--|--|---|--|---------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Balance/Vertigo | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> FAS |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Condition | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Diabetes | Other (specify) _____ | |

If YES to any of the above, please explain: _____

6. Please describe your:

EYESIGHT: Excellent Good Fair Poor Glasses Contacts

HEARING: Excellent Good Fair Poor Require Electronic Hearing Aid

PHYSICAL CONDITION: Excellent Good Fair Poor

SWIMMING ABILITY: Able to swim 100m Able to swim 25m Non-swimmer

Non-swimmers: are you comfortable in deep or moving water while wearing a lifejacket or PFD? Yes No

7. Have you been under a DOCTOR'S CARE in the last 12 month? Yes No

If YES, for what reason? _____

8. Do you have a history of JOINT PROBLEMS (arthritis, tendonitis, bursitis, sprains, dislocation, etc.)? Yes No

If YES, please describe: _____

9. Do you feel you have any PHYSICAL CONSIDERATIONS that could limit your participation? Yes No

If YES, please explain: _____

10. Do you feel you have any PSYCHOLOGICAL CONSIDERATIONS (fear of heights, etc.) that could limit your participation?

Yes No If YES, please explain: _____

11. List any other factors that may affect your participation at Strathcona Park Lodge: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Home Phone: (____) _____

Home Phone: (____) _____

Alternate Phone: (____) _____

Alternate Phone: (____) _____

I hereby give my consent and full authority to the staff of Strathcona Park Lodge to arrange for, and consent to, any emergency medical treatment or hospitalization for the Participant, and to enter into and execute, on my behalf, such documents or consents as may be required by Physicians, Health Care Professionals, Dentists or Hospitals for such purposes.

I have completed this medical form accurately, truthfully, and to the best of my knowledge as of today's date. I understand that it is my responsibility to inform Strathcona Park Lodge of any new medical condition or change to this information before the program begins. I recognize that falsification or omission of information is grounds for removal from the program.

Signature of adult Participant or Custodial Parent/Guardian (for minors): _____

Print Name: _____

Date: _____