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 revealed 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:

☐ ADHD	☐ Motion Sickness	☐ Frequent Colds	☐ Epilepsy	☐ Asthma
☐ Night terrors	☐ Balance/Vertigo	☐ Nosebleeds	☐ Kidney Trouble	☐ FAS
☐ Sleep Walking	☐ High Blood Pressure	☐ Headaches	☐ Heart Condition	
☐ Anxiety	☐ Fainting	☐ 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 limit your participation at Strathcona Park Lodge: _____

_____

IN CASE OF EMERGENCY CONTACT:

Name: _____
Relationship: _____
Home Phone: (_____) _____
Alternate Phone: (_____) _____

Name: _____
Relationship: _____
Home Phone: (_____) _____
Alternate Phone: (_____) _____

In the event that emergency medical treatment or hospitalization is required for the Participant, and I am not immediately available for consultation, I hereby give my consent and full authority to the directors of Strathcona Park Lodge to arrange for, and consent to, any such treatments as may be required by Physicians, Health Care Professionals, Dentists or Hospitals for the Participant named above.

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: _____