Participant Medical Information

Information on this form will only be accessible by men on the medical team. The information will also be used to ensure activities being planned will keep every man safe. Questions? Please contact Rob (paramedic) at **rsouthcott@shaw.ca** **or 604 414 8910**

# Personal Information:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_ Email:

 Phone ◻ Cell: \_\_\_\_\_\_\_\_\_\_\_ ◻ Home: \_\_\_\_\_\_\_\_\_\_ Personal Health Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Health Issues (Medical History)

|  |
| --- |
|  |

Prescribed Medications

|  |
| --- |
|  |

# Allergies

|  |
| --- |
|  |

# Comments

|  |
| --- |
|  |

# Emergency Contact Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone ◻ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ◻ Home:

◻ I will inform staff of any medical conditions that may affect my health during the activities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Participant name (printed) |  | Participant Signature |  | Date |

Send forms to rhinoofbalance@gmail.com or fill out online at thorswarriors2018.weebly.com