Participant's Medical Form

Name:_____

BC Med Care card #_____

Date of birth (year, month, day):_____

Parent/guardian's name:_____

Address:_____

Phone # (hm)_____(wk)_____(cell)_____

Emergency contact name:_____ ph #_____

Medical History
(please circle yes'Y' or no'N' to the following questions)

1. Has your child ever suffered any form of **Asthma**? **Y N**
If yes, do they take any medication for it? What type?
_____

2. Has your child ever suffered any form of **Allergy**? **Y N**
If yes, what are they allergic to and what, if any, medication is taken?
_____

3. Does your child have any of the following conditions?

Phobias	**Y N**	Diabetes	**Y N**
Epilepsy	**Y N**	Bleeding disorder	**Y N**
Heart condition	**Y N**	Migraines/headaches	**Y N**
Seeing disorders	**Y N**	Hearing disorders	**Y N**
Ankle/knee/joint problems?	**Y N**		

Please provide details of questions for which 'yes' was answered:_____
_____
_____

Please turn over page

4. Date of last Tetanus injection?_____

(if not within last 10 yrs, participant may receive a tetanus injection by a medical officer if they receive a tetanus prone wound)

5. Is your child on any ongoing medications?
Please provide details of medications, dosage and frequency taken:_____
_____
_____
__
Do you give permission to your child to self administer these medications? **Y / N**

6. Do you give permission for your child to be given non-prescription medications for the following conditions?
Pain/fever (e.g. Tylenol, Advil) **Y N**
Cold/flu tablets **Y N**
Bites/stings/hay fever/allergy (e.g. antihistamine) **Y N**

7. Is there anything about your child's situation that we need to be aware of in regards to his/her participation in this program(example: Behaviour or medical concerns)? **Y N**
If Yes, please explain:

8. In the case of accident or illness, I authorize the caregiver to administer first aid and/or be taken to the nearest emergency centre. I consent for my child to receive medical treatment. I consent that in the event of severe illness/injury the means of transportation may be by ambulance at a cost to myself. **Y N**
_____**Initail**

I Declare that the information which I have provided on this form is complete and correct and that I will notify the program if any changes occur. I authorise the facilitator who is with my child to consent, where it is impractical to communicate with me, for my child to receive such medical or surgical treatment as may be deemed necessary.

SIGNED …… (Parent/ Guardian)

DATE: ……