

MEDICAL DISCLOSURE FORM



Name (participant):

Date of Birth: Age:..... Gender: Male / Female

Height:..... Weight:.....

Skidegate Band Number?:.....

Please fill out this form as accurately as possible. All forms are confidential and will only be used by Swan Bay Rediscovery staff for the duration of the participants program.

EMERGENCY CONTACT INFORMATION

Name:.....

Relationship:.....

Phone Number: (-----) Day: (-----)

Doctors Name:.....

Phone Number: (-----)

Health Care Number:

Date of last Tetanus Inoculation or Booster:.....

*It is important to note that **tetanus inoculation** is an easy way to protect yourself from the disappointment of having to be evacuated due to a simple cut or scrape. Call your health care worker if you are unsure about your inoculation date. A tetanus shot is good for ten years and can save your life.*

Do you wear glasses or contact lenses?-----Yes / No

Can you swim? -----Yes / No

Rate swimming ability: sinker floater dog paddler swimmer champion

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Have you or do you now have any of the following conditions:

(Please check box(s) that apply and briefly describe below)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis----- | <input type="checkbox"/> Asthma----- |
| <input type="checkbox"/> Diabetes----- | <input type="checkbox"/> Dizziness----- |
| <input type="checkbox"/> Ear aches----- | <input type="checkbox"/> Epilepsy----- |
| <input type="checkbox"/> Eye Problems----- | <input type="checkbox"/> Frostbite----- |
| <input type="checkbox"/> Headaches----- | <input type="checkbox"/> Heart condition----- |
| <input type="checkbox"/> Hepatitis----- | <input type="checkbox"/> High Blood Pressure----- |
| <input type="checkbox"/> Malaria----- | <input type="checkbox"/> Menstrual Problems----- |
| <input type="checkbox"/> Frequent Nosebleeds----- | <input type="checkbox"/> Sleepwalking----- |
| <input type="checkbox"/> Stomach Problems----- | <input type="checkbox"/> Frequent Toothaches----- |
| <input type="checkbox"/> Other----- | |

Are you under treatment for any illness or condition? If so please name and describe:-----

Have you suffered any of the following injuries: (please provide date of injury)

- | | |
|--|---|
| <input type="checkbox"/> back pain----- | <input type="checkbox"/> concussion----- |
| <input type="checkbox"/> dislocation----- | <input type="checkbox"/> fracture----- |
| <input type="checkbox"/> joint problems----- | <input type="checkbox"/> bad sprains/strains----- |
| <input type="checkbox"/> Other----- | |

Do you have any other injuries that might effect your ability to participate? If so please describe injury including date and lasting effects:-----

Are you currently taking any form of medication? If so please give name, dosage, frequency and any possible side effects:-----

Do you have any allergies? If so please list them, including the type of reaction (including allergic reactions to medications):-----

Do you have any dietary restrictions? (vegetarian, lactose intolerance): If so please describe:-----

Do you have any limitations, fears or phobias? If so please describe them:-----

Have you been hospitalized or in a doctor's care in the past three years? If so please describe and give dates:-----

I _____ (parent/guardian name), declare that the information in this medical form is accurate and truthful. I recognize that omitting or providing inaccurate information may endanger myself and/or my child.

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Parent/Guardian Signature: _____

Date: _____