PARTICIPANT MEDICAL FORM

Note to Parent/Guardian, or Participant

1) **The information on this form may be used by your parish leadership representatives to medical personnel to administer to authorize appropriate heath care and medical attention for the participant as needed.**
2) **This form must be returned to the person responsible for the programming. You may be asked to review and update this form periodically throughout the year**
3) **It is also recommended that you attach a photo on the reverse side of this form**

CONTACT INFORMATION (PLEASE PRINT)			
Surname			**Telephone** *(primary)*
Given name(s)	**Gender** ☐ M ☐ F	**Date of Birth** yyyy mm dd	**Email**
Parent/Guardian Name:	**Telephone (primary)**		**Telephone (secondary)**
Address **Street number** **Street**		**City**	**Postal code**
Province	**Country**		
If participant is under 18: Please provide contact information for parent/guardian			
Surname			**Telephone (primary**
Given name(s)			**Telephone (secondary)**
Email			
Address **Street number** **Street**		**City**	**Postal code**
Province	**Country**		

EMERGENCY CONTACT		
Primary Contact	**Name**	**Telephone** **(home)** **(other)**
Secondary Contact	**Name**	**Telephone** **(home)** **(other)**

MEDICAL INFORMATION

Family Doctor	**Telephone**

Provincial Health Number

Does the participant have any physical, emotional or behavioural limitations/challenges that would require assistance and/or modifications to the program to enable them to participate fully?

☐ Yes ☐ No

Are there any special instructions for the ministry leadership regarding the participants health care and/or diet?

☐ Yes ☐ No

If yes, please explain:

Does the participant wear: ☐ Corrective lenses (glasses) ☐ Contact lenses

If the participant has allergic reactions to such things as food, insects, etc. please complete the following:

Allergy	Life Threatening?	Allergy	Life Threatening?
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

Can the participant recognize when he/she is having an allergic reaction?	Does the participant carry an ANA kit?	Does the participant carry an EPIPEN?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Previous Illnesses	☐ Appendicitis ☐ Rheumatic Fever ☐ Kidney disease ☐ Scarlet Fever ☐ Measles (red) ☐ Mumps ☐ Chicken Pox ☐ Heart Condition ☐ Other	If you've checked any of the boxes, please give details	
Currently suffering from	☐ ADD/ADHD ☐ Asthma ☐ Diabetes ☐ Migraines ☐ Epilepsy ☐ Enuresis ☐ Heart Condition ☐ Motion sickness ☐ Other	If you've checked any of the boxes, please give details	

To the best of my knowledge, my child is in good health. I will notify the leadership if my child is exposed to an infectious disease during the three weeks prior to participation. In case of an emergency I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician, selected by the leadership to hospitalize, secure proper treatment, order injection, aesthetic or surgery for my child.	Signature of parent/guardian: _____

MEDICATION (prescription and non-prescription)

To ensure the health and safety of all, medications brought with the participant shall be the responsibility of the leadership and must be presented at registration. Medications cannot be administered unless the authorization below has been completed and signed. In the case of non-prescription medications, the signature of a parent/guardian is adequate. This includes non-prescription medications such as Aspirin, Gravol, etc. Medications to be given upon the order of a physician require authorization by him/her in writing and the leadership should have in their possession enough medication for the duration of the event.

For those under 18: Any medication (over the counter and/or prescribed) required by participant must be brought with her in original packaging with dosage instructions and clearly labelled with their name. Medications are to be given to the ministry leadership upon arrival. The ministry leadership will supervise the taking of medication of under aged participants according to instructions provided. Participants must be willing to take their medication. They will not be given medication that is not provided by parents/guardians.

OTHER COMMENTS:

SIGNATURE

I certify that the information on this form is complete and current. I hereby authorize the ministry leadership to provide medical assistance and direction (e.g. Contacting EMS/ambulance) where deemed necessary for the health and safety of myself and/or my child/ward during activities. I agree to accept financial responsibility in excess of the benefits allowed by my provincial health plan or the Diocesan Insurance Plan

Signature: _____ **Date:**_____