Medical Information – *must be completed by all participants*

Course Name: _____ Dates: _____

Your Name: _____
Address: _____
Postal Code: _____ Phone (h): _____ (w) _____ (cell): _____
Health Plan Name & Number: _____
Other Medical Plan Name & Number: _____
Physician's Name: _____Phone #: (____)_____-_____

In case of Emergency, Contact:
Name _____ Relationship _____
Address _____ Telephone # (h) (____) ____ _____

Name _____ Relationship _____
Address _____ Telephone # (h) (____) ____ _____

Medical History

Do you have any known allergies or have you ever had a severe allergic reaction? If yes, please describe what causes the reaction, what happens when you have a reaction, and any medications you take or carry for the condition. Please include dosage, frequency and expiry date of medication. _____
_____
_____
_____
_____

Please list any medical conditions (heart condition, high blood pressure, diabetes, chronic headaches, nosebleeds, asthma, emphysema, or other) any psychological and physical conditions (seizure disorders, depression, previous dislocations, breaks, recent surgery) that may effect your ability to participate in the program you have registered for. Please describe all past and present problems, how they effect you, the signs and symptoms of onset, and what triggers them. _____
_____
_____
_____
_____

Are you on any prescription or non-prescription medications? No _____ Yes _____
If yes, please specify name, dosage, frequency, and tell us why you are taking it.
_____
_____
_____

Do you wear a Medic Alert? Yes ____ No _____ Details: _____
_____

Date of last Tetanus Shot (they are valid for 10 years) _____
A valid tetanus shot is mandatory for all multi-day courses and trips.
General Physical Condition: good ___ fair ___ poor ___
Do you have any physical limitations? No ____ Yes ____ If yes please specify _____
_____
Any shoulder problems? No _____ Yes _____ (Please describe): _____
_____
_____
Eye sight: (please check applicable) Good eyesight _____ Poor Eyesight _____
Wear Glasses_____ Wear Contacts _____ Comments _____
Please describe any dietary restrictions _____
_____

In the case of the participant being under the age of eighteen (18) in the Province of Alberta, or under the age of responsibility elsewhere, I hereby give permission to a course/trip representative of the Alberta Whitewater Association. to arrange any medical treatment required by my child or ward while she/he is under the care of the chaperone or guide during the program named above.

Parent/Legal Guardian Signature: _____
Date: _____ Participant's Name: _____

If you are bringing medication with you.

- Bring twice as much as you are required to take the entire length of your program, and pack it in two waterproof and UV proof containers.
- List your name, the name of the drug, and the dosage and frequency instructions on the outside of each container.
- Give one container to your instructor/guide in case you lose or damage your own.
- Make sure your medication has not expired

I have completed this medical form accurately and truthfully, and to the best of my knowledge. I understand that any injury or illness that is aggravated by, or as a result of my participation in this program and any evacuation costs arising thereof, is solely my responsibility and I therefore release Alberta Whitewater Association., its directors, managers, employees, and associates from any future claim I might make against them. I understand that it is my responsibility to inform Alberta Whitewater Assocation. before my program starts, of any medical condition that may arise after filling out this form.
Signed this _____ day of _____ in the year _____ .

Participant Signature: _____

Witness Signature: _____

CONSENT TO EMERGENCY MEDICAL CARE FOR MINOR CHILDREN

Further to the consent for emergency medical care for minor children the following conditions apply to consent for my child.

NAME _____

DATE OF BIRTH _____

That reasonable effort must be made to contact me for consent for treatment at all of the following phone numbers, in priority of appearance on this form:

NAME OF PARENT	PHONE 1	PHONE 2	PHONE 3

IN the event that my child's life is in imminent danger, the emergency Physician has my consent to deliver emergency medical care deemed necessary to alleviate the imminent danger while attempting to contact me, or in the event that I am unable to be contacted.

Signature: _____

Name (printed): _____

Relationship to minor child: _____

Date: _____

Signature: _____

Name (printed): _____

Relationship to minor child: _____

Date: _____