

WRCC Medical/Health Information Sheet

Name: _____ Date of Birth: _____

Parent: (if under 18) _____

Phone: (H) _____ (B) _____ Cell: _____

Address: _____

Ontario Health Number: _____ Family Dr: _____

Phone : _____

CPR QUALIFIED: Yes/No Year of Qualification: _____

General Medical Conditions

Please indicate any significant medical conditions, physical limitations, dietary restrictions or any other concerns that might affect you/your child's full participation in club activities. Give details of usual treatment for each of the conditions you list.

Do you/your child take prescribed medication on a regular basis? Please specify.

Do you/your child wear or carry medical alert identification. Please specify.

Allergies/Asthma

Please list all known confirmed allergies to the following: Is allergy considered mild/moderate/severe

FOOD: _____

MEDICATION: _____

OTHER: _____

Do you have an Epi-Pen or puffer for your condition? _____

If **yes**, do you carry it with you at all times? _____

Where do you keep it? _____

Signature: _____ Date: _____

Signature of Parent: _____ (if under 18)