

The information you provide will remain completely confidential, and hopefully will not have to be used. We will destroy this information after the TriAdventure.



TRIADVENTURE

MAKE A WORLD OF
DIFFERENCE

09

Medical Form

Participant Name _____

Street Address _____

Birth Date (mm|dd|yy): _____

City/Province _____

Postal Code _____

Home Phone No. _____

Cell Phone No. _____

OHIP Card No. _____

OHIP Version No. _____

Family Physician: _____

Physician's Phone: _____

IN CASE OF EMERGENCY

Contact Name _____

Relationship _____

Contact Number _____

Cell Phone No. _____

Can we release medical information to this person? Yes___ No___

Do they have your authorization to make medical decisions for you? Yes___ No___

MEDICAL HISTORY

Do you have any medical problems that we should be aware of? _____

Allergies to medications or certain food (please list) _____

Environmental allergies (e.g. bee sting) _____

Have your allergies ever been so severe that you required hospitalization? _____

Do you carry an EpiPen? Yes___ No___ If yes, do you use it often? _____

Please list the medications you are taking on a regular basis _____

Do you have medication that needs to be refrigerated? Yes___ No___ Name: _____

Please list the medications you take as needed: _____

When was your last tetanus shot? _____