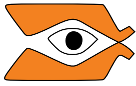

STRATHCONA PARK LODGE MEDICAL FORM

PLEASE PRINT CAREFULLY. This information helps us provide for your dietary and medical needs.

SCHOOL/GROUP: **PROGRAM DATE:**

PARTICIPANT INFORMATION

Name:	Age:	Date of Birth (*m/d/y*):
	Gender:	Preferred Pronoun:
Address (*street/city/province/postal code*):		
BC Care Card #:	Other Health Insurance:	

Parent/Guardian Name:	**Emergency Contact Name:**
Email:	Email:
Phone:	Phone:
Alternate Phone:	Alternate Phone:

FOOD ALLERGIES	**Reaction** (*bring* ***two*** *Epi Pens if any are required*)	**Epi Pen required?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

FOOD RESTRICTIONS

☐ Gluten Free
☐ Celiac Disease
☐ No Pork
☐ No Red Meat
☐ Pescatarian (*fish, eggs & dairy ok*)
☐ Lacto Ovo Vegetarian (*eggs & dairy ok*)
☐ Lacto Vegetarian (*dairy ok*)
☐ Vegan
☐ Lactose Intolerant (*small amount ok*)
☐ Disordered Eating
☐ Picky Eater
☐ Other (***use back page to describe***)

ALLERGIES (*environmental or medication*)	**Reaction** (*use back page if needed*)	**Treatment** (*bring* ***two*** *Epi Pens if any are required*)

HEALTH INFORMATION (*use* ***back page*** *or* ***attach care plan*** *if necessary*)

☐ Glasses/Contacts
☐ Hearing Aid
☐ H/L Blood Pressure
☐ Heart Condition
☐ Asthma
☐ Diabetes
☐ Other health information:
☐ Recent Concussion
☐ Migraine Headache
☐ Seizure Disorder
☐ Recent Injury (*describe*)
☐ Frequent Infection (*describe*)
☐ ADHD
☐ Autism
☐ Panic Attacks
☐ Depression/Mood Disorder
☐ Anxiety/Phobia (*describe*)
☐ Bedwetting

PRESCRIBED MEDICATIONS *Please list medication name, what it is used for, dosage and time given.*

LAST TETANUS SHOT IMPORTANT! Children in BC receive a tetanus booster in Kindergarten and Grade 9.

☐ Within last 5 years ☐ Within last 10 years ☐ Not immunized

SWIMMING ABILITY ☐ Able to swim 100m ☐ Able to swim 25m ☐ Non-swimmer

Non swimmers: Are you comfortable in deep water while wearing a lifejacket? ☐ Yes ☐ No

CONSENT TO MEDICAL TREATMENT In the event of a medical emergency, if I am not immediately contactable, I give my consent to treatment to the health care providers (doctors, hospital medical staff, first aid attendants) chosen by the directors of Strathcona Park Lodge, to provide whatever treatment is medically necessary for the Participant.

I have completed this medical form accurately, thruthfully, and to the best of my knowledge as of today's date.

____
Signature of adult participant or parent/guardian for youth

____
Today's date (*m/d/y*)