OUTDOOR EDUCATION
Medical Info Form

- ✓ **THIS FORM MUST BE COMPLETED AND RETURNED.**
- ✓ **INFORMATION IS COMPLETELY CONFIDENTIAL.**
- ✓ **PLEASE PRINT IN INK.**
- ✓ **THE FIRST AID PERSON WILL CARRY THIS FORM ON THE TRIP.**
- ✓ **PLEASE FILL OUT CONTACT NUMBERS CAREFULLY.**
- ✓ **YOU MUST ANSWER ALL OF THE AREAS (DO NOT LEAVE BLANK).**
- ✓ **THIS FORM MUST BE HANDED IN BY Feb. 7th, 2014.**

STUDENT'S NAME:_______________________________CARE CARD NUMBER: _______________

CONTACT INFORMATION

Name and Number of person to call in case of an emergency:

1st choice name:_____________________ Relationship___________________
Home phone:________________________ Cell phone:____________________
Work phone:________________________

2nd choice name:____________________ Relationship___________________
Home phone:________________________ Cell phone:____________________
Work phone:________________________

Physician's Name:___________________ Clinic phone:___________________

ALLERGIES/DIETARY RESTRICTIONS

Do you have any known allergies (or dietary restrictions) or have you ever had an allergic reaction? Yes No
Have you ever had a severe (Anaphylactic) reaction? Yes No
If "Yes" to **either** question please describe what causes the reaction, what happens, and any medications you take or carry:

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MENTAL/PSYCHOLOGICAL HISTORY

Please check all that apply to your psychological condition and give details below.

- ❑ Fear of Heights
- ❑ Fear of Water
- ❑ Fear of Animals/ Insects
- ❑ Eating Disorder
- ❑ Depression
- ❑ ADD/ADHD
- ❑ Addiction
- ❑ Recent Emotional Stress
- ❑ Recent Mental Stress
- ❑ Other (See Below)

Including the above, please list any/all mental or psychological conditions that may affect your ability to participate in the program you have registered for. Please describe all past and present problems, how they affect you, what are the symptoms of onset, and what brings them on:

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Is your condition/state controlled by medication or other means? Yes No Explain below.

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TETANUS INOCULATION HISTORY

Tetanus boosters are free and good for ten years. A current one is mandatory to participate.
What was the date of your last Tetanus inoculation or booster? Month? ______ Year? ____

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL/PHYSICAL CONDITION AND GIVE DETAILS BELOW

- ❑ Problems with blisters in the past?
- ❑ Bursitis
- ❑ Past History Of Frostbite
- ❑ Inner Ear or Balance Problem
- ❑ Previous Head Injury
- ❑ Infectious Disease
- ❑ Suffer From Migraine Headaches
- ❑ Chronic Joint Injuries
- ❑ Poor Eyesight
- ❑ Hearing Deficiency
- ❑ Asthma
- ❑ Chronic Hypoglycemia
- ❑ Tendonitis
- ❑ Achilles Tendonitis
- ❑ Arthritis
- ❑ Chronic "Ankle Sprainer
- ❑ Recurrent Infections
- ❑ Angina
- ❑ Other (See Below)

Including the above, please list any/all medical conditions (heart disease, diabetes, etc.) & physical conditions (seizure disorders, bad back, joint problems, etc.) that may affect your ability to participate in the program you have registered for. Please describe all past and present problems, how they affect you, what are the symptoms of onset, and what brings them on:

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Is your condition/state controlled by medication or other means? Yes No Explain below.

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MEDICATIONS

Please list any medications, both prescription and non-prescription, and their details below.

Medication	Dosage	Frequency	Reason Taken	Side Effects	Expiry Date

If you are bringing a medication on which your quality of life depends with you, please:

- Ensure that it has not expired!
- Bring twice as much as you need for the length of your program.
- Pack it in two separate waterproof and sun proof containers.
- Print the name of the drug on each container.
- List detailed dosage and frequency instructions on each container.
- Have your Doctor or Pharmacist print out a sheet for you that describes adverse effects, contra indications, overdose treatment, etc. (from CPS)
- Give the printed sheet, along with half of your medication(s), to your guide in case yours is lost or damaged

SIGNATURES

I have read and completed this medical form, accurately, and truthfully, to the best of my knowledge. I understand that it is my responsibility to inform my teacher before my program begins, of any medical conditions that may have arisen after filling out this form.

Signed the _________day of ___________, 2014

____________________________________ ____

Participant Signature Parent or Guardian

School use only

Received Date:__________________________

Initials:_____________

Notes:____

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- ❑ Physician Call required
- ❑ Parent Call required