



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

SCHOOL/GROUP: _____

Program Date: _____

PARTICIPANT INFORMATION

Name:	Usual first name	Age:	Date of Birth (m/d/y):	Gender: M	F
Address (street/city/province/postal code):					
BC Care Card #			Other Health Insurance:		

Parent/Guardian:	Emergency Contact:
Email:	Relationship:
Phone:	Phone:
Alternate Phone:	Alternate Phone:

FOOD ALLERGIES	Reaction (Bring two Epi Pens if required)	Epi Pen required?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

FOOD RESTRICTIONS

- Gluten Free
- Celiac Disease
- No Pork
- Other (use additional page if necessary)
- No Red Meat
- Lactose intolerant (small amount OK)
- Vegan
- Lacto ovo vegetarian (eggs & dairy OK)
- Lacto vegetarian (dairy OK)
- Pescatarian (fish, eggs & dairy OK)

ALLERGIES (Environmental or medications)

ALLERGIES (Environmental or medications)	Reaction	Treatment (bring 2 Epi Pens if required)

HEALTH INFORMATION Please attach a separate sheet or care plan if necessary

- Glasses/Contacts
- Hearing Aid
- Heart Condition
- Other significant health information:
- Diabetes
- ADHD
- Autism
- Recent Concussion
- Seizure Disorder
- Migraine Headache
- Recent Injury (describe below)
- Frequent infection (describe below)
- Anxiety/Phobia (describe below)
- Bedwetting
- Asthma
- H/L blood pressure

Prescribed Medications Please list medication name, what it is used for, dosage, time given.

Tetanus Shot IMPORTANT INFORMATION. Children in BC receive a tetanus booster in Kindergarten and Grade 9.

- Tetanus (within last 5 years)
- Tetanus (within last 10 years)
- Choose not to immunize

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, truthfully, 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)