

ALIVE OUTDOORS - MEDICAL FORM

In order to be permitted to participate in all activities please fill out this form and return it to your school as soon as possible. A physical exam by your doctor is <u>not</u> required. Please be as detailed as possible. Providing full disclosure allows us to provide appropriate care.

PERSONAL INFORMATION:			
Participant Name:		Date of Birth:	
Permanent Address:			
Parent(s) Name(s):			
		Parent Cell Phone #:	
Parent Work Phone #:		Parent Work Phone #:	
Parent Email:			
IN THE EVENT OF AN EMERGENCY:	C	AN BE CALLED AT:	
	(Contact Name)		(Contact Phone)
OUID #-			
OHIP #:	 ude a health insurance numb	er helow	
There is no orni mamber, preuse men	ade a ficalifi modrance namb	ci below.	
HEALTH INSURANCE #:			
(Please send photocopy of insurance, if			
COMFORT IN THE WATER:			
Regardless of the participant's swimmin			
Device (PFD), and are supervised by qu	-	water-based activities. Ple	ease help us by identifying
the participant's comfort in and around	d the water.		
Confident and comfortable in	the water	mer Does not and c	annot swim
Family Physician:		Participant's Weig	ght:
	Participant's Height:		
ALLERGIES:			
Peanuts	Fish/Shellfish	□ Milk	
Tree Nuts	Soy	Eggs	
Wheat	Bees or Wasps	Penicillin	
Other:	bees or wasps	_ (Please list all details be	
HAS AN ALLERGY BEEN IDENTIFIED AS	ANAPHYLAXIS? NO Y	ES (If "YES" describe in de	tail below)
IS AN EPI-PEN REQUIRED FOR A KNOW	VN ALLERGY? 🗌 NO 🗌 YES	(If "YES" 2 Epi-Pens must	be sent to the program)
Please provide details on the severity a	and treatment of any known a	allergies. IT IS IMPORTAN	T THAT YOU PROVIDE AS
MUCH DETAIL AS POSSIBLE ON ANY A			
TREATMENT HELPS.			

To the best of my knowledge,	all ALIVE Outdoors activities, except as noted above for ergency, and I am not immediately available for cuctors and/or first aid personnel selected by the camp nospitalization, injections, transfusions, anesthesia or above.
To the best of my knowledge,	all ALIVE Outdoors activities, except as noted above for ergency, and I am not immediately available for ructors and/or first aid personnel selected by the camp nospitalization, injections, transfusions, anesthesia or
program or trip. Attach a separate page if necessary.	
program or trip. Attach a separate page if necessary.	
List all regular medications as well as all non-prescription me	edicines or supplements that will be brought to the
Provide details of any other physical or emotional concerns trip.	for which treatment may be necessary at the program or
Provide details of all major or recent medical concerns, illnes	sses, operations, injuries or treatments.
Other significant medical issues requiring full awarenes	
☐ Asthma ☐ Heart/Circulato ☐ Bleeding Issues ☐ Concussion(s)	ry Issues
☐ Diabetes ☐ Debilitating Spo	
Seizures or Epilepsy Sleep Walking	☐ Nosebleeds
MEDICAL CONCERNS: Please indicate any medical issues the participant has been t	treated for:
Are all other immunizations up-to-date?	
IMMUNIZATIONS: Has the participant received a Tetanus shot within the last 1	0 years? YES NO
	
	Lactose Intolerant
☐ Vegan ☐ Other:	
Other:	Gluten Intolerant
☐ Vegan ☐ Other:	Gluten Intelerant