MEDICAL INFORMATION

Name: _____

Address: _____

_____

In case of emergency, please contact:

Name: _____

Relationship: _____

BC Care Card – Personal Health No: _____

Medical Insurance Plan: _____

Group No.: _____ ID No.: _____ Dependent No.: _____

Medical History

Known allergies: _____ Last Tetanus Booster: _____

Are you on any medication? ☐ Yes ☐ No

If yes, please specify: _____

Have you been under a doctor's care in the last 3 months? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any physical limitations? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any psychological limitations (e.g. fear of water, heights, etc.)? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any chronic disabilities (please check applicable problems):

☐ Previous dislocations ☐ Heart condition ☐ High blood pressure ☐ Epilepsy ☐ Diabetes
☐ Headaches ☐ Nosebleeds ☐ Emphysema ☐ Asthma ☐ Back problems
☐ Other –please specify:

_____

_____

Signature: _____ Date: _____