

**Medical Information** – *must be completed by all participants*

Course Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone (h): \_\_\_\_\_ (w) \_\_\_\_\_ (cell): \_\_\_\_\_

Health Plan Name & Number: \_\_\_\_\_

Other Medical Plan Name & Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**In case of Emergency, Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone # (h) (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone # (h) (\_\_\_\_) \_\_\_\_\_

**Medical History**

Do you have any known allergies or have you ever had a severe allergic reaction? If yes, please describe what causes the reaction, what happens when you have a reaction, and any medications you take or carry for the condition. Please include dosage, frequency and expiry date of medication. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medical conditions (heart condition, high blood pressure, diabetes, chronic headaches, nosebleeds, asthma, emphysema, or other) any psychological and physical conditions (seizure disorders, depression, previous dislocations, breaks, recent surgery) that may effect your ability to participate in the program you have registered for. Please describe all past and present problems, how they effect you, the signs and symptoms of onset, and what triggers them. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you on any prescription or non-prescription medications? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, please specify name, dosage, frequency, and tell us why you are taking it.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wear a Medic Alert? Yes \_\_\_\_ No \_\_\_\_ Details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of last Tetanus Shot (they are valid for 10 years) \_\_\_\_\_

A valid tetanus shot is mandatory for all multi-day courses and trips.

General Physical Condition: good \_\_\_ fair \_\_\_ poor \_\_\_

Do you have any physical limitations? No \_\_\_ Yes \_\_\_ If yes please specify \_\_\_\_\_

Any shoulder problems? No \_\_\_\_\_ Yes \_\_\_\_\_ (Please describe): \_\_\_\_\_

Eye sight: (please check applicable) Good eyesight \_\_\_\_\_ Poor Eyesight \_\_\_\_\_

Wear Glasses \_\_\_\_\_ Wear Contacts \_\_\_\_\_ Comments \_\_\_\_\_

Please describe any dietary restrictions \_\_\_\_\_

In the case of the participant being under the age of eighteen (18) in the Province of Alberta, or under the age of responsibility elsewhere, I hereby give permission to a course/trip representative of Aquabatics Calgary Ltd. to arrange any medical treatment required by my child or ward while she/he is under the care of the chaperone or guide during the program named above.

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Participant's Name: \_\_\_\_\_

**If you are bringing medication with you.**

- Bring twice as much as you are required to take the entire length of your program, and pack it in two waterproof and UV proof containers.
- List your name, the name of the drug, and the dosage and frequency instructions on the outside of each container.
- Give one container to your instructor/guide in case you lose or damage your own.
- Make sure your medication has not expired

I have completed this medical form accurately and truthfully, and to the best of my knowledge. I understand that any injury or illness that is aggravated by, or as a result of my participation in this program and any evacuation costs arising thereof, is solely my responsibility and I therefore release Aquabatics Calgary Ltd., its directors, managers, employees, and associates from any future claim I might make against them. I understand that it is my responsibility to inform Aquabatics Calgary Ltd. before my program starts, of any medical condition that may arise after filling out this form.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ .

Participant Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_