Solstice Recreation Group - Medical Form

The following information is used to identify any medical related condition and contact information for each participant. Each participant must fill out the required information in order to participate in Solstice Recreation Group programming. The information that you provide is strictly confidential and is shredded at the completion of your program.

Name:_____Date of Birth:_____

Address:_____

Home Phone:_____BC Medical #:_____

Current Medical Conditions:_____

Allergies ?_____yes_____no If so please detail Allergies_____

Do you carry an Epi-Pen for these Allergies?_____yes_____no

Please check if any of the following apply to you:

___Asthma ___Glasses ___Angina ___Seizures ___Diabetes ___Pregnant ___Back Pain

Any other medical related issues that Solstice Recreation Group should be made aware of:

___yes ___no. If yes please explain_____

Emergency Contacts:

1. Name: _____ Relationship: _____

   Home Phone: _____ Emergency Phone: _____

2. Name:_____ Relationship: _____

   Home Phone: _____ Emergency Phone: _____

Medical Treatment Consent: "While my underage child is participating in Solstice Recreation Groups programs, I hereby give permission for Solstice Recreation Group staff to provide treatment, and if needed to arrange medical transportation for them".

_____ _____

Parent / Legal Guardian Signature Date

_____

Please Print Full Name