



## *Solstice Alpine Guides - 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 Alpine Guides 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

Are there any other medical related issues that Solstice Alpine Guides 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: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Medical Treatment Consent:** “While my underage child is participating in Solstice Alpine Guides programs, I hereby give permission for Solstice Alpine Guides staff to provide treatment And if needed to arrange medical transportation for them”.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Full Name