

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: _____ Age _____

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 Can you swim ? _____ 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