



## MEDICAL INFORMATION FORM

Please take the time to fill this out and mail or fax it back to us at **(403) 933-7444**. This enables us to ensure you have a quality time and your needs are looked after. This information is confidential, only your facilitators and our program coordinator will have access to it. Please review our Privacy Policy at [www.full-circle-adventures.com](http://www.full-circle-adventures.com)

Please note: Your state of health must be fully and accurately disclosed on this form so we may be appropriately prepared for an emergency, should one occur. Failing to disclose important health information will result in you not being able to participate in the program you registered for or to receive a refund.

Name: \_\_\_\_\_ (Please Print)

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

Postal code: \_\_\_\_\_ Phone no. (\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_

**Emergency contact number:** (\_\_\_\_) \_\_\_\_\_

**Name of emergency contact person:** \_\_\_\_\_

Do you have any previous injuries the facilitators should know about?

E.g. knee surgery, lower back problems, broken wrist.

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

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

Do you have any health problems the facilitators should know about?

E.g. Ulcers, diabetes, heart problems, asthma.

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

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

Are you currently taking any medication?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which medication and what is it for? \_\_\_\_\_

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

Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_.

If yes, what are you allergic to? \_\_\_\_\_.

What are you taking for it? \_\_\_\_\_.

Are you on any sort of special diet or certain food requirements?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_.

Are you covered with Alberta Health Care or Blue Cross?

Yes \_\_\_\_\_ No \_\_\_\_\_

We would like to have your Alberta Health Care number, in case of an emergency. Of course it is optional to fill out this request.

AHCIP Number \_\_\_\_\_.

Additional Comments or Concerns: