



Medical / Surgical Authorization & Contact Form

Last Name : _____ First: _____ Middle: _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____

Birthdate: _____ Age: _____
(As of October 1st, of this year)

Country of Birth: _____ Are you a Canadian Citizen? Yes No

Is the member allergic to any medication and/or food? Yes No

If 'yes', list the allergies: _____

In case of sickness, may this member take one dose of: Aspirin Ibuprofen Acetaminophen Gravol

Does this member wear contact lenses? Prescription Glasses?

Does this member suffer from Hay Fever? Allergies? Asthma?

Does this member take any regular medication including injections or inhalers? Yes No

List any medications taken on a regular basis. _____

Any previous severe illness, injury or surgery? Yes No When? _____

If yes, please provide details _____

Any other health history that may assist the person in charge should this member become ill:

First contact in case of emergency

Parent/s or Guardian's Name/s: _____

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Other phone: _____
(specify)

Family physician

Name: _____ Phone: _____

Other emergency contact(s)

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

WE HAVE HEALTH OR ACCIDENT INSURANCE YES NO If 'yes', please complete the following questions.

Insurance Company Name: _____

Group Number: _____ Policy Number/Certificate Number: _____

Does this policy include out-of-country coverage? Yes No

We have attached a copy of our Insurance card to this form: Yes No

This form has been filled out to the best of my knowledge. I hereby authorize medical or surgical treatment of _____ in the event of any emergency, illness or accident. I accept all responsibility and liability for any occurrence or accident, which may occur during this member's participation in the guard. The Ventures Winter Colour Guards do not provide any accidental death, disability, dismemberment, dental, or medical expense insurance on behalf of the members participating in guard activities.

Signature of Parent or Guardian

Signature of Parent or Guardian

Date (mm/dd/yyyy)