Ventures
winter colour guard

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)