Medical History Form - Confidential

INTERNATIONAL CANADIAN SCHOOL OF SURVIVAL INC.

I.C.S.O.S.

_____

Participant's Name

We urge you to be completely thorough in providing the information requested. This information will only be viewed by the staff who are responsible for your safety and well-being, and will only be shared with medical professionals in the event of an emergency.

Medical Coverage

Does the participant have provincial coverage? ⬛ Yes ⬛ No

Province: Health Card #: _____

If the participant does not have provincial medical coverage, please indicate private or alternate medical insurance below:

Insurance Company:

Policy #: _____ Expiry: ___ / ___ (mm / yy)

Group Number: _____

Address: _____

Phone #: _____

Medical Information

Do you have any physical conditions that may limit or restrict your full participant in this activity? ⬛ Yes ⬛ No Please specify:

_____

_____

_____

Do you have any dietary allergies or restrictions: ⬛ Yes ⬛ No

Please specify:

_____

_____

_____

Do you have any non-dietary allergies? ⬛ Yes ⬛ No Please specify:

_____

_____

_____

Do you have any allergies that are likely to result in an anaphylactic reaction?

⬛ Yes ⬛ No Please specify:

_____

_____

_____

Please Note: Clients with anaphylactic reactions are required to bring an epi-pen.

Are you taking any medications? ⬛ Yes ⬛ No

Please list any and all medications taken and the conditions they are taken for:

_____

_____

_____

Do you have asthma? ⬛ Yes ⬛ No

Has it been stable* for the past year? ⬛ Yes ⬛ No

**controlled with medication and not requiring medical treatment in the past 12 months*

Please describe asthmatic triggers:

_____

_____

_____

Do you have diabetes? ⬛ Yes ⬛ No

Do you have a history of cardiovascular disease or conditions? ⬛ Yes ⬛ No

(eg. valve disorder, murmurs, angina)

Please specify:

_____

_____

_____

Do you have a seizure disorder? ⬛ Yes ⬛ No Please specify:

_____

_____

_____

Have you had a tetanus immunization (or booster shot) within the past 10 years?

⬛ Yes ⬛ No

Have you had frostbite, a significant reaction to cold temperatures, or other circulatory problems? ⬛ Yes ⬛ No

(eg. Raynaud's Phenomenon)

Please explain and describe severity:

_____

_____

_____

Is there anything else of a medical nature the staff should be aware of?

⬛ Yes ⬛ No Please specify:

_____

_____

_____

I certify that I have a satisfactory level of health, mental stability, physical fitness and endurance for my participation in the activity and have completed the Medical History Form accurately, understanding that ICSOS will be relying upon this medical information disclosed by me. Any medical concerns have been discussed with my health care professional, and I have verified that I do not have any physical or psychological problems which could create undue risk to myself or anyone else during the activity.

_____	_____	_____
Participant's Name	Signature	Date (*yyyy/mm/dd*)
_____	_____	_____
Parent / Guardian Name	Parent / Guardian Signature	Date (*yyyy/mm/dd*)