



**BRITANNIA COMMUNITY SERVICES CENTRE**  
1661 Napier Street, Vancouver, B.C. V5L 4X4 Phone 718-5800

**PARTICIPANT MEDICAL INFORMATION**

Please note that the information contained herein is considered confidential and will only be shared with the trip leader and medical personnel in the event of a medical emergency. This information is important - **PLEASE PRINT CLEARLY.**

**PARTICIPANT'S NAME:** \_\_\_\_\_ **BIRTHDATE (d/m/y):** \_\_\_\_\_

**PARENT / GUARDIAN NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

**HOME TEL:** \_\_\_\_\_ **WORK TEL:** \_\_\_\_\_ **ALTERNATE TEL:** \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION – can be another parent / guardian**

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

**HOME TEL:** \_\_\_\_\_ **WORK TEL:** \_\_\_\_\_ **ALTERNATE TEL:** \_\_\_\_\_

**DOCTOR'S NAME:** \_\_\_\_\_ **DR'S PHONE:** \_\_\_\_\_

**B.C. CARE CARD PERSONAL HEALTH NUMBER:** \_\_\_\_\_

**OTHER HEALTH/MED. INSURANCE:** \_\_\_\_\_ **NUMBER:** \_\_\_\_\_

Is your Child subject to any of the following? (circle)

- |               |          |                           |
|---------------|----------|---------------------------|
| Severe Asthma | Diabetes | Seizure Disorder/Epilepsy |
| ADD / ADHD    | Other    |                           |

If yes, please give additional information: \_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**  **LIFE THREATENING/ANAPHYLAXIS** or  **Non life threatening** or  **None**

Foods \_\_\_\_\_  Animals \_\_\_\_\_

Insects \_\_\_\_\_  Grasses/Pollens \_\_\_\_\_

Drugs \_\_\_\_\_  Other \_\_\_\_\_

Describe what happens during a reaction: \_\_\_\_\_  
\_\_\_\_\_

In the event of a reaction, what actions are necessary? \_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized due to a reaction: Yes / No      If yes, when? \_\_\_\_\_

What, if any, medication does your child carry for their allergy? \_\_\_\_\_  
\_\_\_\_\_

CONTINUE ON SECOND SIDE

Has your child been under a **DOCTOR'S CARE** in the last 12 months? Yes / No If **YES**, for what reason?

Does your child suffer any **PHYSICAL LIMITATIONS**? \_\_\_\_\_

Does your child have any **PSYCHOLOGICAL LIMITATIONS** (Eg. fear of heights, fear of water, etc) If yes, describe:

Does your child experience any **BED TIME / SLEEPING DIFFICULTIES**? If yes, describe: \_\_\_\_\_

Does your child have any **DIETARY RESTRICTIONS**? If yes, describe: \_\_\_\_\_

Has your child ever had any **MAJOR ILLNESSES, INJURIES, or OPERATIONS**? Yes / No If **YES**, describe:

Is your child taking **ANY PRESCRIPTION OR NON-PRESCRIPTION DRUGS**? Yes / No

If **YES**, What drug? \_\_\_\_\_ How frequently? \_\_\_\_\_

When was your child's last **TETANUS** Inoculation or Booster (d/m/y)? \_\_\_\_\_

\*\*\*\*[Tetanus shot must be current (within last 10 years) for **ALL** overnight wilderness trips]\*\*\*\*

**EYESIGHT:** Excellent Good Fair Poor Glasses Contacts Laser Eye Surgery

**HEARING:** Excellent Good Fair Poor Require Electronic Hearing Aid

**SWIMMING ABILITY:** None Minimal Able to swim 25m Able to swim 100m Able to swim 1 km

How often does your child swim? Daily Weekly Monthly Several times per year Rarely

Do they have any swimming qualifications? \_\_\_\_\_

#### IMPORTANT NOTES

1. If your child wears **glasses** bring a second pair in case their first pair is broken or lost.
2. If your child wears **contacts** send a pair of glasses as back-up.
3. If your child is bringing **medication**: A. Check the expiry B. Send complete second set (that the instructor can carry) in case the first set is damaged or lost. C. Ensure all medication is labeled with child's name, drug name, dosage and expiry. D. Check with doctor/pharmacist regarding any contraindications or storage restrictions that might be affected by this trip.
4. We may treat our **drinking water** with iodine, chlorine or by boiling. Chemicals are not effective against Cryptosporidium. We recommend that immune compromised people bring an appropriate filter for their trip.

I confirm that the above information is correct and I hereby give consent and full authority for the staff of Britannia Community Centre to arrange for and consent to any medical treatment or hospitalization for my child/ward while he/she is in the care of the community centre. I further authorize these staff members to enter into and execute, on my behalf, such documents or consents as may be required by Medical Practitioners, Health Care Professionals or Hospitals for such purposes.

**I understand that it is my responsibility to inform the staff of *Britannia Community Centre* of any new medical condition or change to the information provided as early as possible.**

SIGNATURE OF PARENT/ GUARDIAN \_\_\_\_\_ DATE (d/m/y): \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ RELATIONSHIP TO MINOR: \_\_\_\_\_