

# PERSONAL HEALTH FORM

## Note to Parent/Guardian

The information on this form may be used by PSAQ representatives or medical personnel to administer or authorize appropriate health care or medical attention for the participant, if needed. You may be asked to review and update this form periodically throughout the year. By signing this form you authorize photocopies to be made of this form. Copies to be kept with the chaperone and on the girls when traveling for emergency purposes only.

Name: \_\_\_\_\_  
Last Name Given Name Birth Date:

Address: \_\_\_\_\_  
City Province Postal Code

Phone: \_\_\_\_\_  
Home Business/Cell Height Weight

### Contact Information of Custodial Parent or Guardian:

Name: \_\_\_\_\_  
Last Name Given Name E-mail

Phone: \_\_\_\_\_  
Home Business/Cell

Address: \_\_\_\_\_  
City Province Postal Code

*In the event of an emergency, if I cannot be reached, the following person is hereby authorized to act on my behalf and has been notified that he/she has been granted this authority and may be contacted by a PSAQ representative".*

Name: \_\_\_\_\_  
Last Name Given Name Relationship

Address: \_\_\_\_\_  
City Province Postal Code

Phone: \_\_\_\_\_  
Home Business/Cell

**Family Doctor:** \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies or other medical information pertinent to registrant? If none, indicate "none".

\_\_\_\_\_ **Care Card Number**

Has this person menstruated?  yes  no If not, has she been told about it?  yes  no

Is the participant subject to any of the following? Arthritis\_\_ Convulsions\_\_ Motion Sickness\_\_

Respiratory ailments\_\_ Ear trouble\_\_ Nightmares\_\_ Headaches\_\_ Sleepwalking\_\_ Other-please specify  
(If more room is needed, please continue on reverse) →

Chronic conditions or recent illnesses of which the Coach should be aware:

Please provide details of treatment required and name of medications she will be bringing with her if required for the abovementioned condition(s).

\_\_\_\_\_ continue on reverse →  
Are there any medications that your child/ward should carry themselves (eg. asthma pump, Epi-pen...)

\_\_\_\_\_ continue on reverse →

### **N.B Every care and attention will be given to the health and comfort of the participant.**

*I hereby authorize a PSAQ representative to secure such medical advice and services (eg., contacting EMS/ambulance as may be deemed necessary for the health and safety of my daughter (or ward) during activities. I agree to accept financial responsibility in excess of the benefits allowed by my provincial health plan:*

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Participant (or custodial parent/guardian if participant is under provincial age of majority) This form is valid for one year.