

Adult Medical Information Form

Full Name	Birth date (mm/dd/yyyy)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Age at program
Address	Home Phone #	Health Card Number <i>(Must be provided)</i>	
City/Province	Postal Code	Local Info (if applicable)	
In Case of Emergency Contact	Phone#(s) ()	Relationship	
	Email:		
Doctor's Name:		Doctor's Phone #:	
Medical Concerns/Allergies: _____ Do you require special medical attention? <input type="checkbox"/> asthma <input type="checkbox"/> allergies: _____ <input type="checkbox"/> other: _____ **If you have a SEVERE ALLERGY, please ask for the Anaphylaxis Data Sheet and Action Plan			

YES	NO	PAR-Q A questionnaire for people aged 15+
		1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
		2. Do you feel pain in your chest when you do physical activity?
		3. In the past month, have you had chest pain when you are not doing physical activity?
		4. Do you lose your balance because of dizziness or do you ever lose consciousness?
		5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
		6. Is your doctor currently prescribing drugs (for example, water pills) for you blood pressure or heart condition?
		7. Do you know of <u>any other reason</u> why you should not do physical activity?
If you answered YES to one or more questions		
Talk with your doctor by phone or in person BEFORE you start becoming much more physically active. Tell your doctor about any of the questions that you answered YES.		

I certify that this document is true and accurate and I agree to advise the Penticton Recreation Department, in writing, of any change in my medical condition. I understand that unless the Penticton Recreation Department hears from me otherwise, they will assume that all medical information is unchanged from the date of this agreement.

Signature of Participant

Date