COMMUNITY RECREATIONAL INITIATIVES SOCIETY
Phone: (250) 979-3941
E-mail: General@adaptiveadventures.ca Web: www.AdaptiveAdventures.ca
Mail: Box 25141 Mission Park P.O. Kelowna, BC, Canada V1W 3Y7

PERSONAL HEALTH AND MEDICAL RECORD

The following information is used to provide CRIS personnel with an assessment of each participant's medical history for safety purposes. This information will remain confidential. Please be as detailed as possible.
It is your responsibility to update CRIS personnel of changes in your health/meds/etc. that occur after filling out your Health and Medical Record.
Please print clearly.

Today's date (d/m/y) ____/____/_____

Surname_____ First name_____Middle name_____Age_____

Date of birth (d/m/y) _____ /_____/_____ Gender (circle) **M F** Height_____Weight_____

Address (street, city, prov, post code)_____

Home Phone_____Cell_____Other_____Email_____

INDEPENDENCE
Is the individual for whom this form is for independent (Cares for self, make decision for self etc.) Circle one **Y N**
_____

PRIMARY DECISION MAKER & SCHEDULING CONTACT (If different from above please note who to speak to for scheduling)
Name_____Relationship_____Address_____

Home phone_____Cell_____Other_____Email_____

DAILY SUPPORT CONTACT
If applicable & different from above please note who will be attending the outings with the participant
1. Name_____Relationship_____Address_____

   Home phone_____Cell_____Other_____ Email_____

2. Name_____Relationship_____Address_____

   Home phone_____Cell_____Other_____ Email_____

EMERGENCY CONTACT
1. Name_____Relationship_____Address_____

   Home phone_____Cell_____Other_____

2. Name_____Relationship_____Address_____

   Home phone_____Cell_____Other_____

PHYSICIAN: Name_____Phone_____Address_____
Insurance carrier_____Policy number_____
Please Note: CRIS does not provide medical insurance for participants or personnel.

BC Medical Number: _____

ALLERGIES: (Food, medicines, insects, plants, chemicals) **Note ANY and ALL**. Explain signs, symptoms & treatment_____

_____

_____

Please check all that apply <u>This list is not complete.</u> Please specify any and all condition(s) or challenges you have. Explain in section that follows.

☐ **Neoplasm (cancers)** Leukemia**,** Cancer	☐ **Circulatory System** High or low blood pressure**,** Irregular heartbeat, Pace maker
☐ **Blood & Blood Forming Organs & Immune system** hemophilia, Anemia, HIV	☐ **Digestive System** Ulcer, Irritable Bowel Syndrome, trouble swallowing
☐ **Congenital & Chromosomal** Huntington's**,** Down's syndrome**,** FASD**,** Autism	☐ **Respiratory System** Asthma**,** COPD
☐ **Mental & Behavioral** Eating disorder**,** Schizophrenia**,** Anxiety**,** Depression**,** memory loss (short or long)	☐ **Skin conditions** Lupus**,** Psoriasis**,** Eczema or dermatitis
☐ **Nervous System** Cerebral Palsy, paraplegia, quadriplegia, Hemeparesis (right or left?) seizures, Neuropathy, spasticity	☐ **Genitourinary system** Severe PMS or menstrual problems**,** Currently Pregnant or breast feeding**,** urinary or bowel issues.
☐ **Injury, or other consequences of external causes** Fractures or breaks, Surgeries, brain injury, amputation	☐ **Musculoskeletal System and Connective Tissue** Osteoporosis**,** Arthritis**,** Scoliosis, neck/spine/back problems,
☐ **Sensory** Deaf**,** partially deaf**,** blind, partially blind, visual neglect, depth perception, colour blindness	☐ **Endocrine, Nutrition and Metabolic** Problems with: Appendix, Kidney, Liver, Thyroid, Gallbladder, Hernia, Diabetes, Hypoglycemia, Heartburn
☐ **Other considerations** **Motion sickness, Fainting/dizziness, Intolerance to warm temperatures, Intolerance to cold temperatures, Intolerance to light, Hepatitis (A, B and/or C), Tuberculosis, Migraines, Sleepwalking**	

If you have checked any of the above boxes **<u>please provide details</u>** (date/s, treatment, current status etc. **Additional space on back of last page**

_____

_____

_____

_____

_____

_____

_____

Are you taking <u>ANY</u> medications? (Prescription, over the counter, homeopathics, herbal supplements) **Yes** **No** Please list them.

_____

_____

_____

_____

Will you be bringing these medications with you when participating with CRIS? **Yes** **No**

Do you have a stoma? **Yes** **No** Do you use a catheter? **Yes** **No**

Mobility: Are you independently ambulatory? **Yes** **No** Ambulatory with an assistive device **Yes** **No**

Please provide a list of any assistive devices you will using when participating with CRIS (manual or power wheelchair, crutches, walker, cane, braces/orthotics etc) _____

Please list any other devices i.e. hearing aid, glasses, contacts, communication devices, dentures etc. _____

_____

Transfer abilities: Do you Transfer independently? **Yes** **No** With assistance from another person or device? **Yes** **No**
Please explain ideal transfer_____

Communication: Average communication abilities, uses Sign language, apraxia, aphasia (receptive/expressive), uses communication device, does not communicate_____
Do you use nicotine products? **Yes** **No** if yes how much/day_____
Do you drink coffee? **Yes** **No** If yes how much and frequency? _____
Do you currently have a substance abuse or chemical dependency issue (drugs, alcohol, etc.)? **Yes** **No**
_____
_____
Do you have a history of chemical dependency? **Yes** **No** (If yes please briefly describe)
_____
_____

Please indicate below what vaccinations you have had (provide date of last shot)

☐ **Tetanus**	☐ **Hepatitis**	☐ **Chicken Pox**
☐ **Diphtheria**	☐ **Mumps**	☐ **HPV Vaccine**
☐ **Pertussis**	☐ **Rubella**	☐ **Travel vaccinations**
☐ **Measles**	☐ **Polio**	☐ **Other (explain)**

Please list any other immunizations you have had
_____
_____
Have you had any major illnesses since any of these shots? **Yes** **No** If yes what was the illness?
_____
_____
Diet Restrictions: _____
_____
Please list any medical or physical concerns that have not been covered in the above answers that may affect your participation in programs offered by CRIS. (i.e. pain, range of motion limitations,)
_____
_____
_____
_____

*****THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AS OF*****

THIS DAY_____ **OF**_____ **20**_____
(Day) **(Month)** **(Year)**

_____ _____
Participant Legal Name (print clearly) **Participant Signature**

SIGNED THIS DAY_____OF_____20_____
(Day) (Month) (Year)

_____ _____
Name of parent or legal guardian (If under the age of 18 or unable to sign) Signature of parent